Oroville Hospital

Community Health Needs Assessment

2022

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Executive Summary

The health concerns identified in this CHNA for 2022 build on prior years' assessments and responses. Many of the top health concerns are unchanged from 2019 due to the interruption in activities resulting from COVID-19, although the Action Plan has been updated to note progress being made. Overall, since there are similar concerns between the 2019 and 2022 CHNAs, the Action Plan items proposed in 2019 continue to be needed by the community.

Response to the pandemic shifted priorities and resources across the world and throughout all industries, although healthcare likely sustained a greater impact from COVID-19 than other business lines. Oroville Hospital responded quickly and utilized a range of local, regional, and national resources to address the COVID-19 pandemic, successfully implementing policies, process and protocols to protect the health and safety of employees, patients and the community. The hospital is pleased to note that concerns surrounding infectious and contagious diseases such as COVID-19 did not arise in the CHNA process as a continuing concern. Treatment, infection control, education, prevention, and vaccination programs remain active throughout the service areas as part of the hospital's commitment to the health and wellness of the Oroville community.

Oroville Hospital remains committed to implementing the actions identified through the CHNA process to meet the needs of the community. Some of the actions are long term, such as the expansion of the hospital to increase capacity and access to care, and the creation of the Plumas House to support individuals without housing to recover and receive services. Where projects have been successful, such as hosting the farmers market and donating services and food, the hospital will continue to support and invest in those projects. Other actions taken are focused on lifestyle and behavioral change, and may take significant time before change is realized across the service area. The hospital will continue programs to address, reduce and prevent heart disease, obesity, diabetes and stroke through education and support of the behavioral choices and changes needed by individuals to make a difference in their health and wellbeing.

Mental health continues to play a role in the health and wellbeing of residents throughout the primary and secondary service areas. The effects of depression and anxiety inhibit healthy choices and directly correlate with impacted health and chronic disease instability. Understanding and addressing the impact of mental health issues in disease treatment will require collaborative partnerships across specialties and resource providers in the community. Oroville Hospital will continue to collaboratively partner with community-based agencies and hospital teams and departments to provide a wide range of integrated services from prevention through to treatment and wellness.

The CHNA process, including the collection of primary and secondary data, provides a fresh opportunity to be forward thinking and to look at the needs of the community for the next three years and beyond. Overall, Oroville Hospital has made progress to address the health concerns and needs within the greater community. The impact of actions is tangible and reflects increased services and resources in response to unmet needs. The hospital will continue to prioritize activities within its Action Plan that correspond with this CHNA as it strives to provide the best quality patient care for anyone that walks through its doors.

Oroville Hospital Community Health Needs Assessment (CHNA)

Introduction and Description of Oroville Hospital

Oroville Hospital is an independent, non-profit corporation located in Northern California. It proudly serves the residents of Oroville and the surrounding foothill and valley communities.

Oroville Hospital's primary service area (PSA) covers 16 zip codes around the cities of Biggs (95917), Gridley (95948), and Oroville (95965, 95966), plus the unincorporated communities of Bangor (95914), Berry Creek (95916), Brownsville (95919), Clipper Mills (95930), Challenge (95925), Feather Falls (95940), Forbestown (95941), Palermo (95968), Rackerby (95972), Richvale (95974), and Strawberry Valley (95981). There are two secondary service areas served by Oroville Hospital that are described in the Community and Service Area section below.

Strongly committed to the 2010 Patient Protection and Affordable Care Act, as well as the values of equity and inclusion within and outside the Hospital, this Community Health Needs Assessment (CHNA) is part of Oroville Hospital's continuing process of ensuring that services are responsive to the needs of the community. This 2022 CHNA includes the community's perspective regarding health care needs and availability of services for those living and working in the Oroville Hospital's service area. In developing the CHNA, care was taken to ensure that input was received from a broad spectrum of the community, including those that use Hospital services and those with knowledge and expertise in public health, business, government, community planning, and social services.

Nonprofit hospitals, such as Oroville Hospital, are required by the Internal Revenue Service to conduct a CHNA every three years and to adopt an implementation strategy for addressing unmet needs identified through the CHNA process. Components of the CHNA include (a) defining the community served; (b) assessing the health needs within the community; (c) obtaining input from persons representing a broad range of interests; (d) preparing a written report for adoption by the hospital board of directors; and (e) making the report available to the public. Furthermore, this CHNA includes an (a) assessment and presentation of priorities within the communities served by Oroville Hospital; (b) identification of resources available and strategies to address priorities; and (c) an evaluation of the impact of actions taken as a result of the previous CHNA completed in 2019.

About Oroville Hospital

Oroville Hospital, located in Oroville, California, is a private IRS-recognized 501(c)(3) non-profit corporation. The Hospital serves residents of the city of Oroville, and surrounding Butte County and North Valley communities. Oroville Hospital provides laboratory services, within its service areas and throughout the North State, including the cities of Orland, Yuba City, Redding, and Grass Valley. Oroville Hospital's mission is to provide personalized health care to residents of Oroville and the surrounding foothill and valley communities. This is accomplished by offering residents a medical home with a wide range of integrated services that begin with education, prevention, and wellness, and includes a range of medical services, diagnosis of diseases, responses to emergency events,

surgeries, life cycle events, patient care, and rehabilitation and skilled nursing services, as well as outpatient and recuperative care services including physical and occupational therapies.

Oroville Hospital is an acute care facility that specializes in a range of inpatient and outpatient services, including multiple specialty physician practices. Oroville Hospital currently has 153 beds. Upon completion of the hospital expansion project, the hospital will add 58 additional beds for a total capacity of 211 beds.

Oroville Hospital's complete service line includes:

- Aesthetic Medicine
- Ambulatory Care
- Anesthesia Services
- Anticoagulation Services
- Cancer Care Program
- Cardiac Catheterization
- Cardiac Rehabilitation
- Cardiology
- Cardiovascular Testing
- Childbirth Services
- Chiropractic Services
- Dentistry Services
- Dermatology
- Ear, Nose, and Throat
- Emergency Care Services
- Endoscopy
- Gastroenterology
- General Surgery
  - Breast
  - Colon & Rectal
  - Vascular
- Home Health
- Hospitalist Services
- Intensive Care Unit
- Laboratory Services
- Medical-Surgical Unit
- Mental Health Services
- Nephrology
- Neurodiagnostics
- Neurology
- Nutritional Therapy
- Obstetrics & Gynecology
- Ophthalmology
- Orthopedic Surgery
- Pain Management
- Palliative Care Program
- Pediatric Services
- Pharmacy
- Podiatry
- Post-Acute Care Services
- Primary Care Services
- Pulmonary Function Testing
- Radiology Services
- Rehabilitation Services
  - Occupational Therapy
  - Physical Therapy
  - Speech Therapy
- Respiratory Care
- Robotic Surgery
  - Colorectal
  - General Surgery
  - Gynecology
  - Urology
- Sleep Disorder Testing
- Stroke Program
- Surgical Services
- Telemedicine
  - Cardiology
  - Neonatal
  - Neurology
  - Radiology
- Urology
- Medical Imaging
- Vascular Services
- Women's Imaging

In the past three years amid COVID-19, Oroville Hospital recorded the following service units:

Oroville Hospital's Patient Care Statistics

	2019	2020	2021		2019	2020	2021
Births	488	480	425	**Lab Procedures**	2,641,63	1,983,906	2,128,229
Admissions	13,854	13,609	12,933	**Outpatient Clinic**	320,348	311,556	339,606
Emergency Department Visits	28,602	25,050	24,058	**Surgery Cases**	5,900	4,937	4,769

Primary Medical Service Area

Oroville Hospital operates a campus located at 2767 Olive Highway in Oroville, California. Its primary service area includes geographical area ZIP codes in south Butte County, the foothills of Yuba County, and a portion of southeastern Plumas County where the Hospital's market share for hospital services (ambulatory surgery, inpatient, and emergency department) exceeds 10% of all hospital services consumed by residents of the ZIP code and is contiguous with other ZIP codes. Oroville Hospital also exceeds 10% share in two ZIP codes, 95978 (Stirling City), a place not contiguous with other ZIP codes in the primary service area, and 95967 (Paradise), a post-office box only ZIP code with no geographical area.

As reported above, Oroville Hospital's primary service area is 16 zip codes and includes the cities of Biggs (95917), Gridley (95948) and Oroville (95965, 95966), and the unincorporated communities of Bangor (95914), Berry Creek (95916), Brownsville (95919), Clipper Mills (95930), Challenge (95925), Feather Falls (95940), Forbestown (95941), Palermo (95968), Rackerby (95972), Richvale (95974), and Strawberry Valley (95981).

Oroville Hospital Patient Origin and Service Area

Zip Code	Place Name	Patients	Percent of Total	Cumulative Percent	Percent of Zip Code
95966	Oroville	13,101	45.1 %	45.1 %	69.6%
95965	Oroville	8,284	28.5 %	73.6 %	64.2%
95948	Gridley	734	2.5 %	76.1 %	11.1%
95968	Palermo	574	2.0 %	78.1 %	57.8%
95916	Berry Creek	453	1.6 %	79.6 %	62.0%
95914	Bangor	269	0.9 %	81.8 %	58.1%
95917	Biggs	255	0.9 %	82.7 %	15.2%
95941	Forbestown	103	0.4 %	83.0 %	49.5%
95919	Brownsville	87	0.3 %	83.3 %	12.8%
95972	Rackerby	40	0.1 %	83.5 %	48.2%
95967	Paradise	32	0.1 %	83.6 %	12.4%
95930	Clipper Mills	27	0.1 %	83.7 %	30.3%
95974	Richvale	21	0.1 %	83.8 %	18.9%
95925	Challenge	20	0.1 %	83.8 %	16.3%
Other Primary (<10 patients)		13	0.0 %	83.9 %	23.2%

Source: California Department of Health Care Access and Information: Patient Discharge Data, Emergency Department Data, and Ambulatory Surgery Data, 2020.

There also are two secondary Hospital utilization service areas. The first is the Chico/Glenn County area. This is a region that along with the primary service area comprises the Chico radio, television,

Oroville Hospital Patient Origin: Secondary Service Area (Chico/Glenn)

Zip Code	Place Name	Patients	Percent of Total	Cumulative Percent	Percent of Zip Code
95928	Chico	431	1.5 %	85.2 %	2.6%
95926	Chico	415	1.4 %	86.7 %	2.4%
95954	Magalia	366	1.3 %	87.9 %	7.4%
95973	Chico	349	1.2 %	89.1 %	2.1%
95969	Paradise	203	0.7 %	89.8 %	7.2%
95963	Orland	90	0.3 %	90.1 %	1.1%
95988	Willows	73	0.3 %	90.4 %	1.3%
95927	Chico*	42	0.1 %	90.5 %	8.2%
95938	Durham	35	0.1 %	90.7 %	2.1%
95967	Paradise*	32	0.1 %	90.8 %	12.4%
95978	Stirling City	16	0.1 %	90.8 %	10.4%
Other Secondary (Chico/ Glenn, <10 patients)		33	0.1 %	90.9 %	1.3%

Source: California Department of Health Care Access and Information: Patient Discharge Data, Emergency Department Data, and Ambulatory Surgery Data, 2020.

**PO box only zip codes with no geographical area*

and newspaper markets. Social marketing and communications to Oroville residents also reach residents of these places. This market area includes the remainder of Butte County and all of Glenn County. It includes the cities of Chico (95926-95928, 95973), Orland (95963), Willows (95988), the Town of Paradise (95967, 95969), and the unincorporated communities of Artois (95913), Butte City (95920), Durham (95938), Forest Ranch (95942), Glenn (95943), Hamilton City (95951), Magalia (95954), Nelson (95958), and Stirling City (95978).

The other secondary service area is comprised of much of Yuba and Sutter counties and is included due to its proximity to Oroville Hospital. Most of the residents of this area live within 30 miles of the Hospital (45 minutes of driving time). Many residents utilize the specialty services at Oroville Hospital as there is a shortage in the region. This area has its own radio and newspaper markets, although it shares its television with the much larger Sacramento area further south. This Yuba/Sutter secondary service area includes the cities of Live Oak (95953), Marysville (95901), and Yuba City (95991-95993), and the unincorporated communities of Browns Valley (95918), Dobbins (95935), Olivehurst/Plumas Lake (95961), Oregon House (95962), and Sutter (95982).

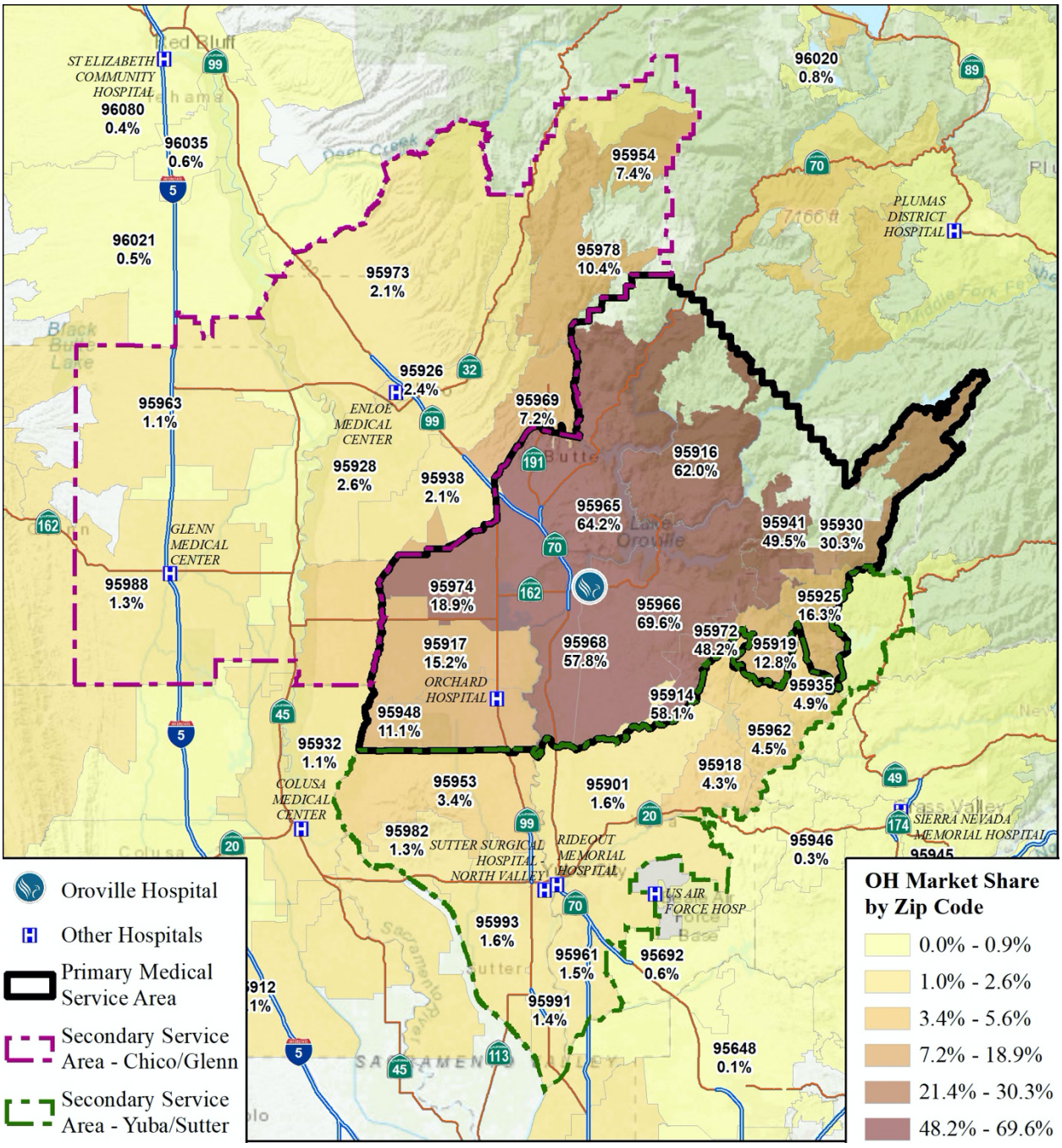
Oroville Hospital Patient Origin: Secondary Service Area (Yuba/Sutter)

Zip Code	Place Name	Patients	Percent of Total	Cumulative Percent	Percent of Zip Code
95901	Marysville	340	1.2 %	92.1 %	1.6%
95991	Yuba City	306	1.1 %	93.2 %	1.4%
95961	Olivehurst	220	0.8 %	93.9 %	1.5%
95993	Yuba City	216	0.7 %	94.7 %	1.6%
95953	Live Oak	169	0.6 %	95.2 %	3.4%
95918	Browns Valley	36	0.1 %	95.4 %	4.3%
95962	Oregon House	20	0.1 %	95.4 %	4.5%
95935	Dobbins	19	0.1 %	95.5 %	4.9%
95982	Sutter	17	0.1 %	95.6 %	1.3%
95992	Yuba City*	11	0.0 %	95.6 %	2.1%

Source: California Department of Health Care Access and Information: Patient Discharge Data, Emergency Department Data, and Ambulatory Surgery Data, 2020.

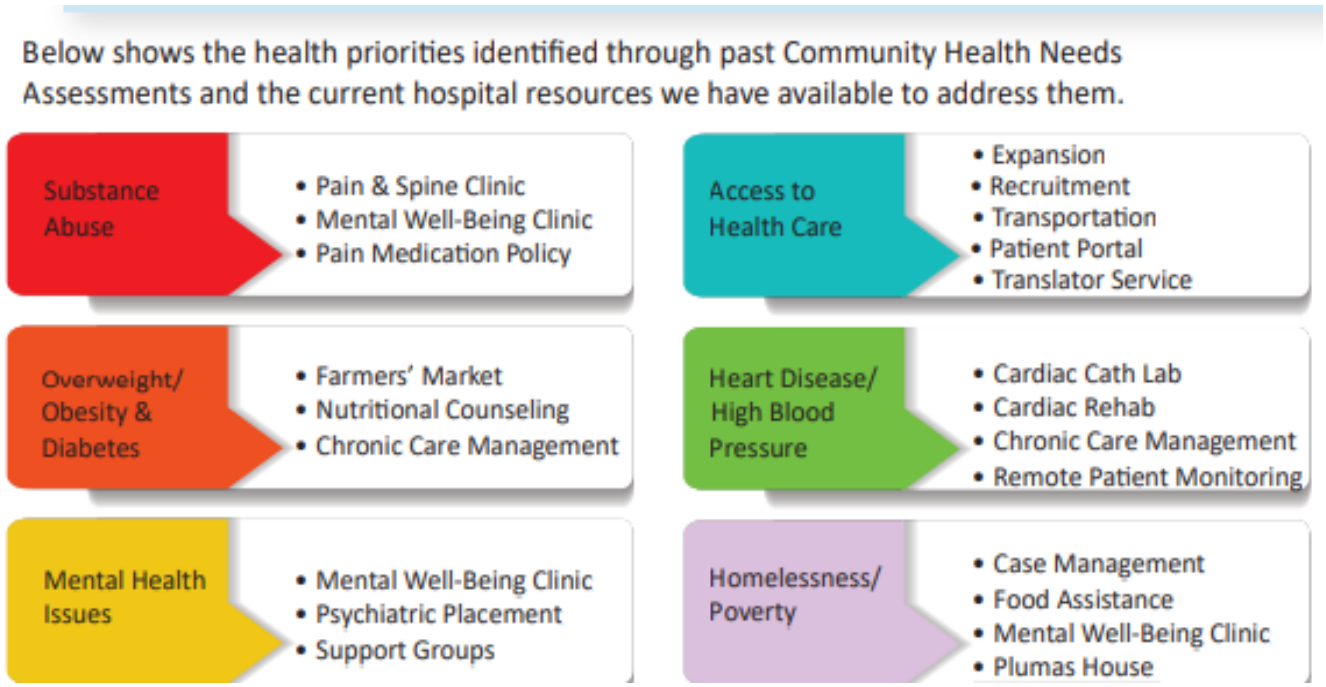
**PO box only zip codes with no geographical area*

The map below shows the location of Oroville Hospital within its primary service areas and includes a patient origination heat map by zip code, and the two secondary service areas.


ST ELIZABETH COMMUNITY HOSPITAL
96080 0.4%
96035 0.6%
96021 0.5%
96020 0.8%
95954 7.4%
95978 10.4%
95973 2.1%
PLUMAS DISTRICT HOSPITAL
95926 2.4%
95963 1.1%
ENLOE MEDICAL CENTER
95969 7.2%
95928 2.6%
95938 2.1%
95916 62.0%
95965 64.2%
95941 49.5%
95930 30.3%
GLENN MEDICAL CENTER
95988 1.3%
95974 18.9%
95966 69.6%
95925 16.3%
95917 15.2%
95968 57.8%
95972 48.2%
95919 12.8%
ORCHARD HOSPITAL
95914 58.1%
95935 4.9%
95948 11.1%
95962 4.5%
95932 1.1%
95918 4.3%
95953 3.4%
95901 1.6%
COLUSA MEDICAL CENTER
95982 1.3%
SUTTER SURGICAL HOSPITAL - NORTH VALLEY
RIDEOUT MEMORIAL HOSPITAL
95946 0.3%
SIERRA NEVADA MEMORIAL HOSPITAL
US AIR FORCE HOSP
95993 1.6%
95961 1.5%
95692 0.6%
95991 1.4%
95648 0.1%
Oroville Hospital
Other Hospitals
Primary Medical Service Area
Secondary Service Area - Chico/Glenn
Secondary Service Area - Yuba/Sutter
OH Market Share by Zip Code
0.0% - 0.9%
1.0% - 2.6%
3.4% - 5.6%
7.2% - 18.9%
21.4% - 30.3%
48.2% - 69.6%

Evaluation of the impact of actions taken to address the health needs in prior CHNA(s)

The 2019 Community Health Needs Assessment (CHNA) and Action Plan identified seven priority health concerns. They were substance abuse, obesity, mental health, access to care, heart disease, diabetes, and homelessness/poverty. The Covid-19 pandemic was declared in March 2020, which required a significant adjustment to the 2019 CHNA Action Plan with resources redirected to the pandemic. Throughout this period, however, Oroville Hospital moved forward with its plans to address the most significant health needs identified. The Hospital prepared the table below to summarize the needs and resources that are in place to address them.



The following is a summary of action taken since 2019. Due to the pandemic some of the activities that were previously implemented were put on hold. The goal is to continue these activities in the future as we begin to spend less resources on the pandemic and are confident in the safety of the community when hosting and participating in larger gatherings.

Mental Health: Mental health concerns in Butte County have always been present due to the lack of psychiatric services available. In 2019, Oroville Hospital worked diligently to expand its Mental Well-Being Clinic which has been providing patients with psychiatric services and counseling. To optimize efficiency between inpatients and outpatients seeking mental health services, the Medical Social Workers at the hospital have restructured to work cohesively as a team, with care providers at the Mental Well-Being Clinic. Oroville Hospital's Mental Well-Being Clinic is able to connect patients with essential mental health care services they need in a safe and welcoming environment. Under the

supervision of Dr. Lynne Pappas, there are now four (4) providers to assist patients in managing their mental health through medication management. For patients who need further assistance, our providers will refer them to receive the care they need. In addition, through Oroville Hospital's Mental Well-Being Clinic, a psychologist provides patients with individual assessments and therapies

Substance Abuse: The growth in capacity at the Mental Well-Being Clinic includes services to those struggling with substance abuse. The Pain and Spine clinic is in place and has a focus on pain management with a conscious awareness of the potential for opioid addiction. Additional training was provided to discuss best practices and guidelines for pain management in the Emergency Department, along with alcohol withdrawal, and neonatal abstinence syndrome. Along with the increased mental health services, the hospital reviewed its pain medication policies and practices to ensure best practices are in place regarding the use and prescribing of addictive medications.

In 2021, Oroville Hospital's Continuing Medical Education (CME) program achieved the highest reaccreditation decision given by the California Medical Association. Oroville Hospital introduced its first Enduring Materials activity, a self-directed, individual course of study in 2020. In 2021, they placed the groundwork for expanding this option by adding the recordings of live CME events onto the HealthStream platform. Each event was built into an Enduring Materials course providing CME credit. The "Opioid Crisis and Alternatives' topic was one of the first 5 events added to the course of study available to providers.

Obesity/Overweight: In an effort to reduce overweight and obesity rates among children, Oroville Hospital offers a nine-week "Fitness for Kids" program that takes place twice a year in the fall and spring. These weekly classes are a fun and interactive way to teach our pediatric patients healthy lifestyle choices that can help keep them healthy throughout their childhood, and into adulthood. A few of the topics that are covered in this program are: how to properly read food labels, the importance of getting daily physical activity and how to set and monitor appropriate health goals.

In addition to the Fitness for Kids program, Oroville Hospital also hosts an annual 3K walk/run specifically designed for children that are at an increased risk of becoming overweight or obese. During this event, members from the pediatric department provide nutrition and exercise information to the children and their parents, while also demonstrating how exercise can be a fun and enjoyable family activity.

Oroville Hospital dietitians offer consultations and education for patients needing assistance with Childhood weight problems - excessive weight gain or failure to gain adequate weight and adult weight problems - obesity and eating disorders. The hospital hosts a weekly farmers market, making fresh produce available to the community.

Diabetes: It is common knowledge that obesity significantly increases the risk of developing diabetes. Everything the hospital does to educate, prevent, and reduce obesity is at the same time reducing the potential for diabetes. In March of 2020, Oroville welcomed a provider to oversee the new Endocrinology Department. The hospital developed and delivered training for providers discussing the holistic approach to diabetic care in October of 2021.

Oroville hospital has implemented and updated a health library available to the public and accessible from the hospital web site. The Diabetes information available is extensive and includes education on

the disease, diagnosis and treatment, resources for more information, along with tools and tips to manage the condition.

Heart Disease/High Blood Pressure: Recognizing that smoking is the leading cause of preventable death in the United States, Oroville Hospital became a smoke-free campus as of March 23, 2020. Research has shown that by having these smoke-free policies in place, there has been a direct improvement in various health outcomes, such as reductions in hospital admissions for heart attacks. Oroville Hospital's Pulmonary Practice also offers a comprehensive Smoking Cessation Program for patients who may need help or want to quit smoking. The specially designed program includes one-on-one appointments with a pulmonologist and personalized cessation plans based on the patient's medical history.

Oroville Hospital has a dedicated Cardiac Cath Lab/Cardio Rehabilitation program. With the completion of the 5-story expansion in the spring of 2023, the hospital will introduce cardiothoracic surgery to its service line. The hospital has recruited and retained both a new cardiologist and a vascular surgeon on staff to provide critical heart and circulatory medical care.

High blood pressure is the number one controllable risk factor for stroke. Oroville Hospital Stroke Support Groups bring together survivors, caregivers, family, and friends. This support group gives individuals a safe space to discuss how stroke has affected their lives. Survivors and caregivers are able to help encourage each other with healing, as well as living a healthier and more positive life. Not only does the support group provide a supportive environment, but it is also a great place for people to gain knowledge, have fun and make new friends.

Access to Healthcare: Oroville hospital has long recognized the challenge to access needed healthcare services in the primary service area. Oroville developed improvements and expanded services to increase access through transportation, telehealth, community clinics, communication translation services, and the expansion of the hospital capacity to provide needed services locally.

To expand access to health care for patients in need, Oroville Hospital instituted a transportation department to facilitate rides for patients free of charge. Not only does this greatly benefit potentially at-risk patients, but the hospital as a whole has also experienced a significant increase in efficiency. Oroville Hospital expanded its telemedicine services, initially, in response to the Covid pandemic. Using the telemedicine option prevents patients from missing essential healthcare appointments, allowing them to meet with their physicians if they do not have the means of transportation to come to the hospital campus.

For individuals who do not have health insurance or restricted access to preventative care, Oroville Hospital hosts Biannual Health Fairs in June and September. These health fairs provide free educational information and demonstrations, free health care advice and free health care screenings. The screenings typically consist of the following services: COPD screening, blood pressure monitoring, oxygen saturation checks, cholesterol checks, pulse checks, blood glucose checks, and free flu shots.

The 2019 CHNA identified language and limitations around the ability to effectively communicate with health care providers as a top priority for individuals who do not speak English or may speak English as a secondary language. To minimize this barrier Oroville Hospital partnered with Stratus, a health

care interpreting service. There are 35 languages including sign language available with the video chat using an interpreter. Additionally, a telephone language line is also available through Stratus 24/7.

In order to increase access to health care locally, Oroville hospital initiated a five-story expansion of the hospital. This expansion will increase the capacity for existing programs and add needed specialty services such as neurosurgery, cardiothoracic surgery, and a trauma 2 designation. The expansion project is estimated to be completed by spring of 2023. It will add an additional 159,000 square feet to the facility, allowing Oroville Hospital to increase from 153 licensed beds to 211.

Homelessness/Poverty: The Hospital recognizes that poverty and homelessness can be a barrier to accessing needed health care. In mid-2020, Oroville Hospital established a new care facility, Plumas House, to assist patients after their stay at the hospital. Plumas House is a six-bed care facility used to provide patients who are displaced with a safe, supportive, and healing environment to rest in. Plumas House provides patients with 24/7 direct care staff, daily meal service, and transportation to medical and dental appointments via Oroville Hospital's Golden Valley Transportation service. Many of the patients who stay at Plumas House struggle with obtaining or meeting their social service needs. While at Plumas house, patients will get to work one-on-one with the on-site Medical Social Worker (MSW). The MSW helps finalize any necessary forms, referrals, phone conferences, and appointments. Additionally, patients may qualify for long-term services based on their unique individual needs. In 2021, Plumas House was able to successfully provide assistance and care to 87 patients.

In 2020, Oroville Hospital provided more than $17 million dollars' worth of charity care and unpaid costs of public programs. In 2021 that number grew to over $18 million. In addition, the hospital provided over $1.9 million dollars in unbilled services to patients unable to pay for care. The hospital continues to provide case management, resource referrals and donations of food and other needs throughout the primary service area.

Survey Results and Data Findings

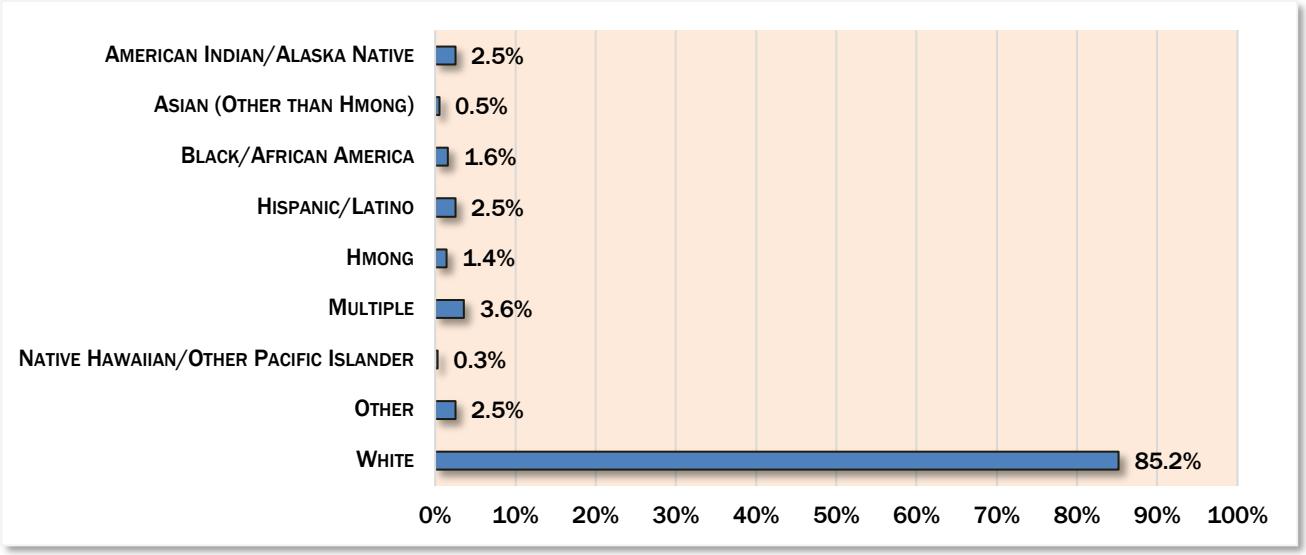
Primary Data

Oroville Hospital broadly disseminated the community needs assessment to residents throughout its primary service area. The following is a profile of respondents in terms of (a) demographic characteristics; (b) perceptions of health; (c) utilization of services for themselves and children; and (d) community issues/concerns. Employees of Oroville Hospital were also invited to contribute to the Community Health Needs Assessment (CHNA), and in a few instances, responses are compared and contrasted between employees and residents. For some reported findings, subgroup analysis is included concerning difference in respondent groups by demographic characteristics.

Demographics of Community Health Needs Assessment Respondents

Three-quarters (74.7%) of respondents completing the Community Health Needs Assessment (CHNA) Survey reported that their gender was female, with 25.3 percent of respondents reporting their gender as male (N=372).[1] The reported race of all respondents is in Figure 1. The reported race of CHNA Survey respondents was overwhelming White (85.2%).

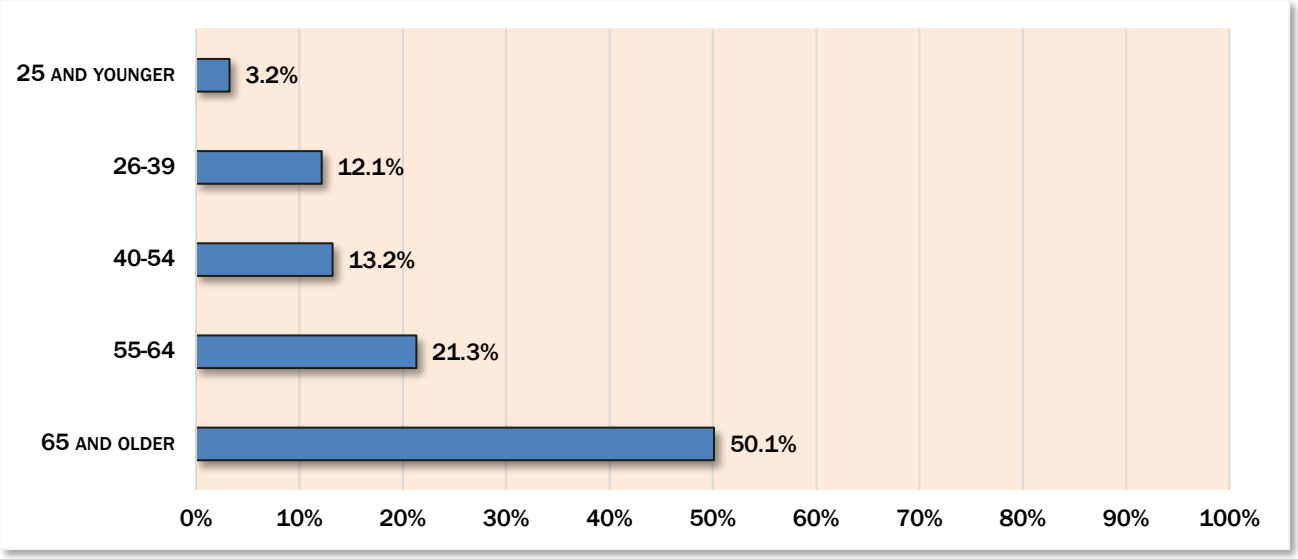
Figure 1: Race of Respondents (N=366)



[1]Five (5) respondents selected the "Chose not to disclose" response in responding to the question, "*How would you classify your gender identity?"*

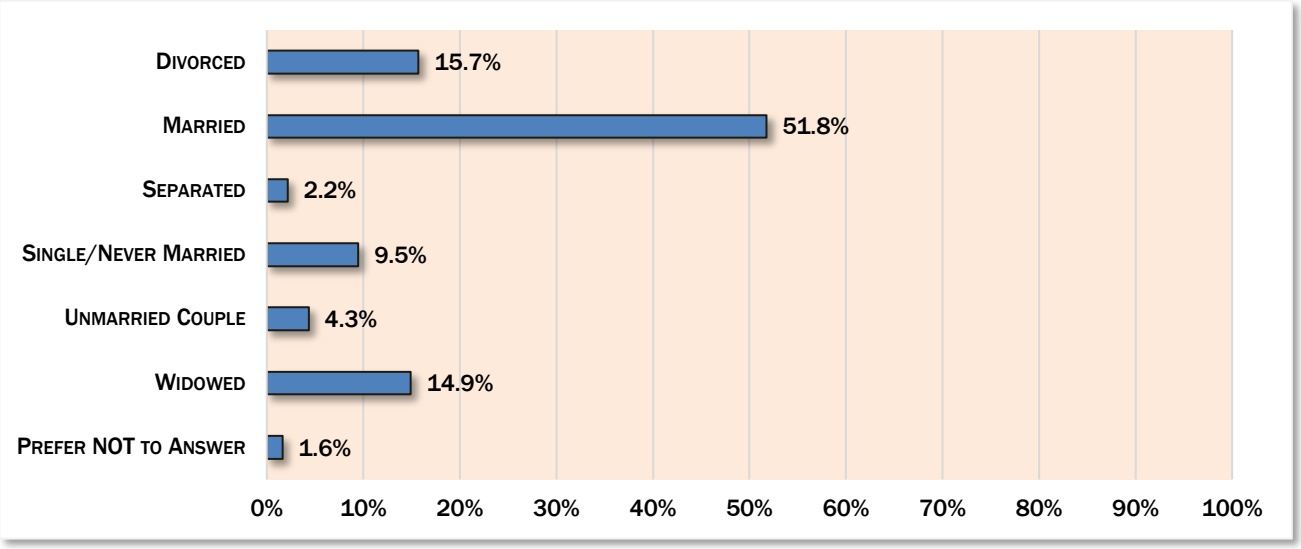
The age range of respondents is reported in Figure 2. A high number of respondents -- one-half (50.1%) -- reported that they were 65 years of age or older.

Figure 2: Age of Respondents (N=371)



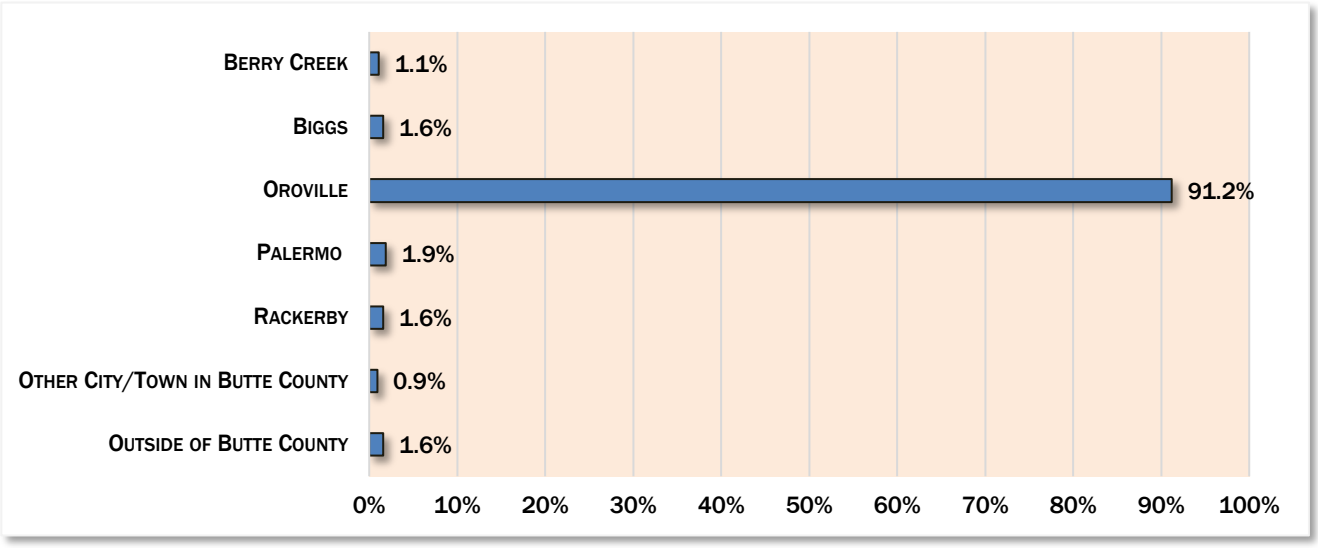
The marital status of respondents is reported in Figure 3. Approximately one-half (51.8%) of respondents reported that they were married.

Figure 3: Marital Status of Respondents (N=369)



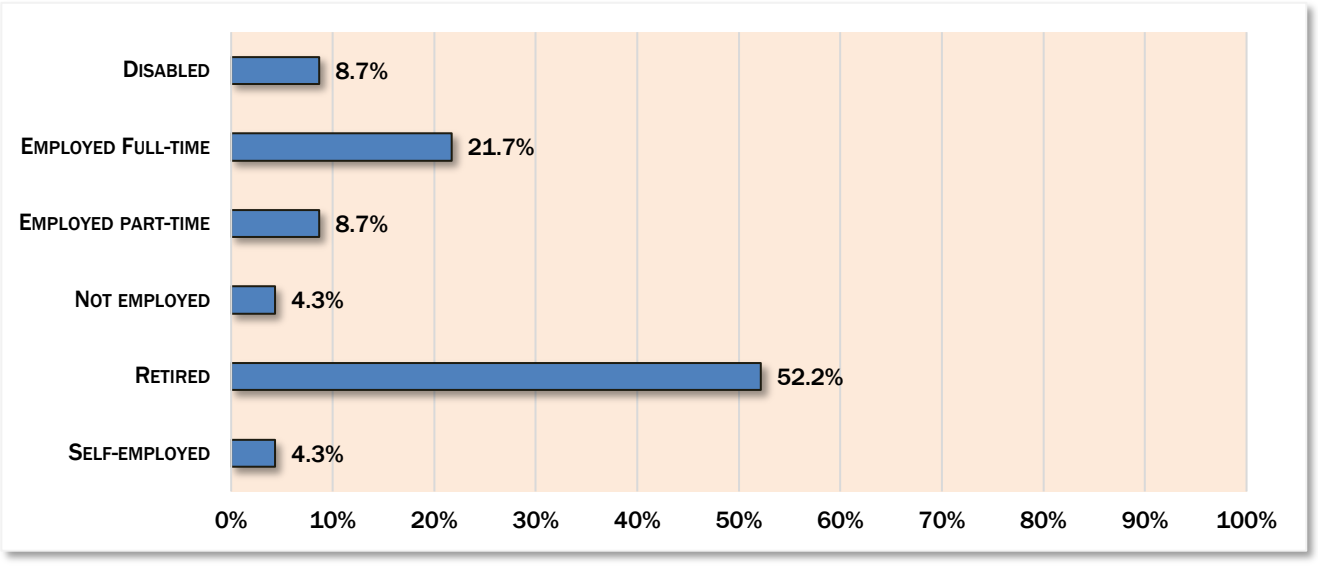
The city or town where of respondents lived[2] is reported in Figure 4. More than 90 percent (90.1%) of respondents reported that they lived in Oroville.

Figure 4: City or Town Where Respondents Lived (N=364)



The current employment status of respondents is reported in Figure 5. Approximately one-half (52.2%) of respondents reported that they were retired.

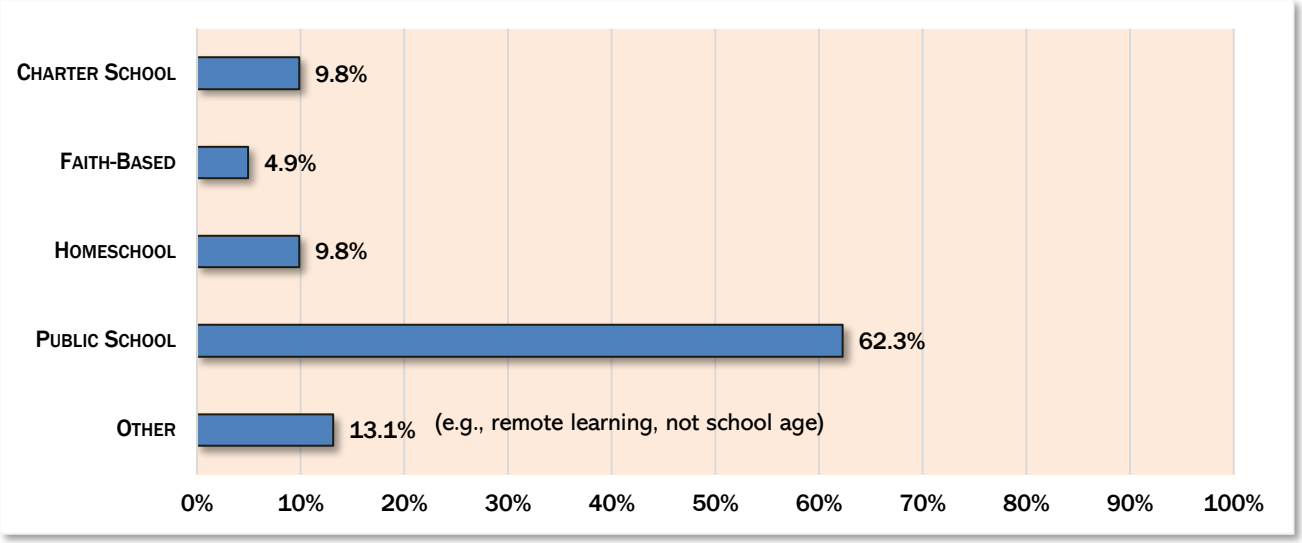
Figure 5: Employment Status of Respondents (N=368)



[2]Survey respondents were asked to report the zip code in which they lived. Zip codes were converted into the city or town represented by the zip code.

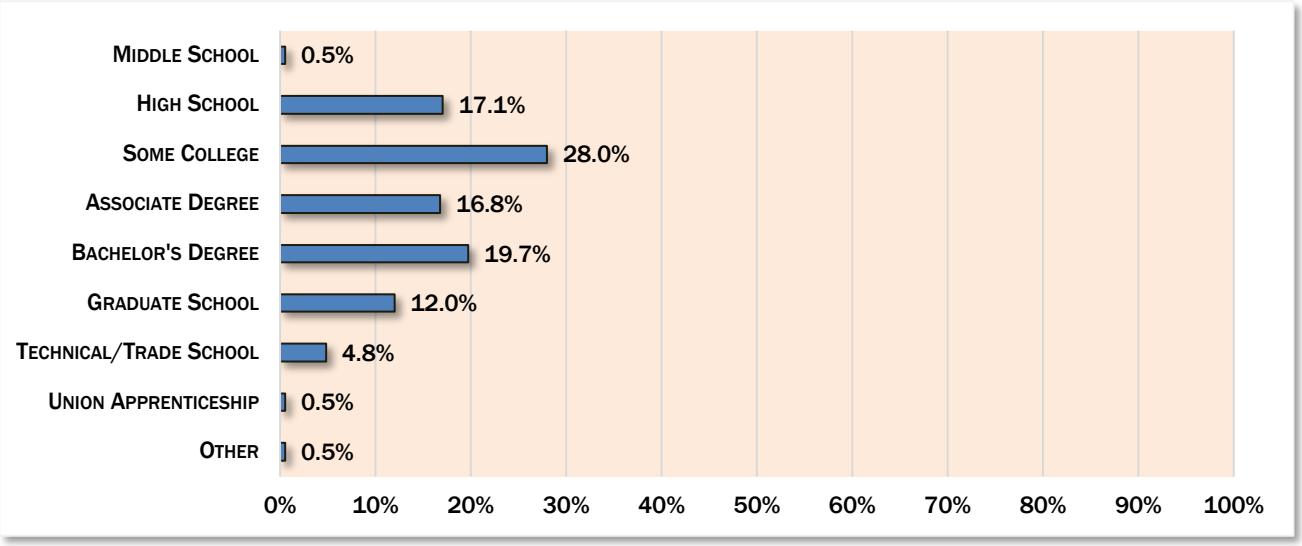
Less than 20 percent (17.6%) of respondents reported that they had a child(ren) under the age of 18 (N=375) residing with them. For those respondents reporting to have a child(ren) under the age of 18, the type of school their child(ren) was enrolled in is reported Figure 6. More than 60 percent (62.3%) of respondents reported that their child(ren) was enrolled in public school.

Figure 6: Type of School in Which Child(ren) are Enrolled (N=61)



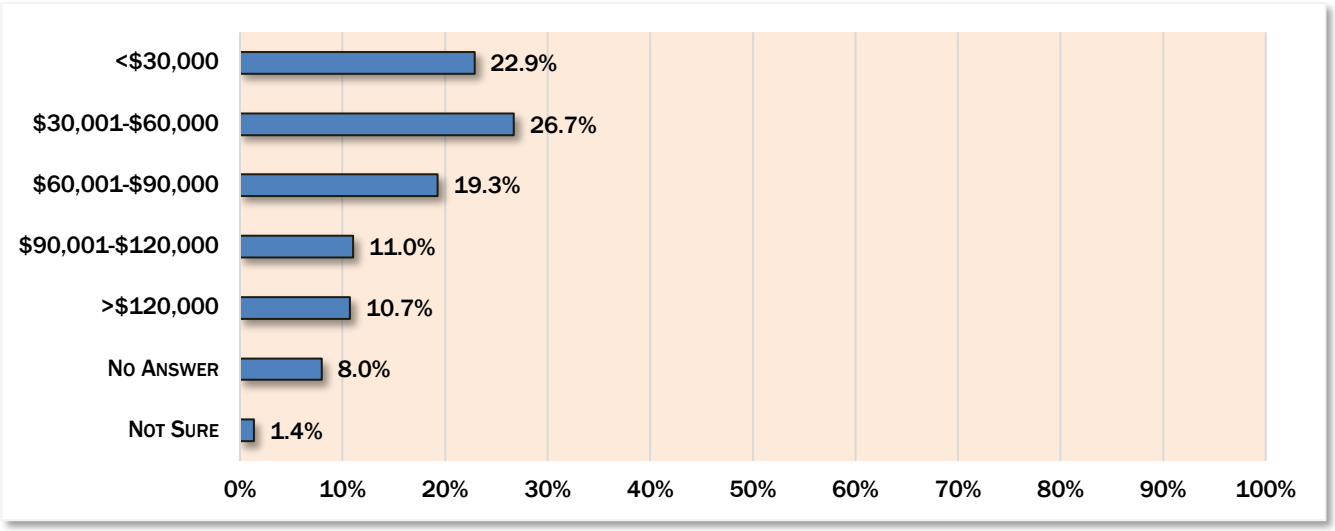
The highest level of education attained by respondents is reported in Figure 7. Forty-five percent (45.1%) of respondents reported that they had some college education or had earned an associate degree.

Figure 7: Highest Level of Education Attained by Respondents (N=375)



Respondents' annual household income before taxes is reported in Figure 8. One-half (49.6%) of respondents reported an annual household income of $60,000 or less.

Figure 8: Annual Household Income Reported by Respondents (N=363)

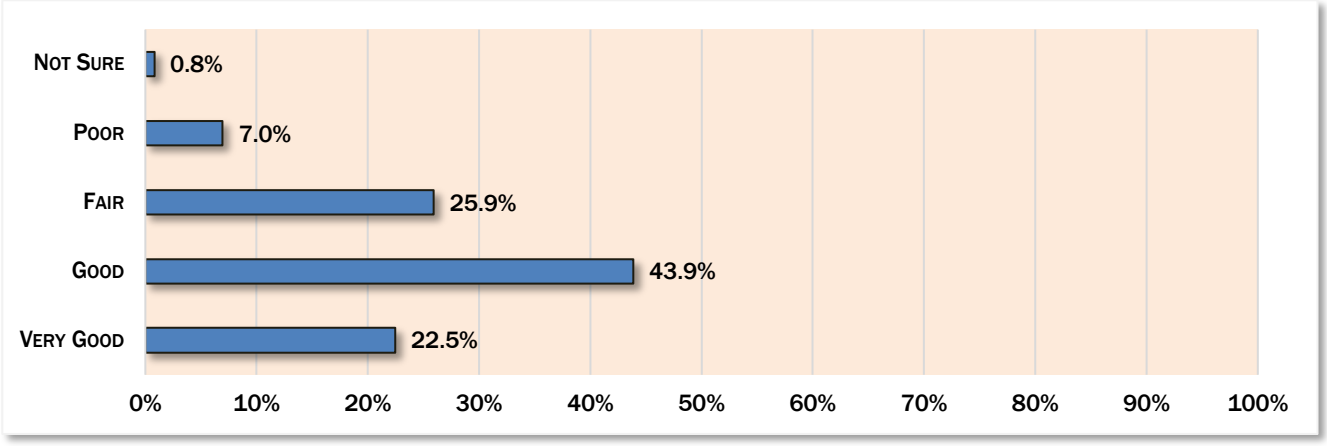


Perceived Health of CHNA Survey Respondents

Individual and Family Level Health and Well-Being

Overall Health of Respondents: Respondents completing the Community Health Needs Assessment (CHNA) Survey were asked to describe their overall health using the following categorical response set: Very Good, Good, Fair, Poor, and Not Sure. The percentage of respondents for each category of the response set is reported in Figure 9. Two-thirds (66.3%) of respondents reported their overall health as good or very good.

Figure 9: Overall Health of Respondents (N=374)



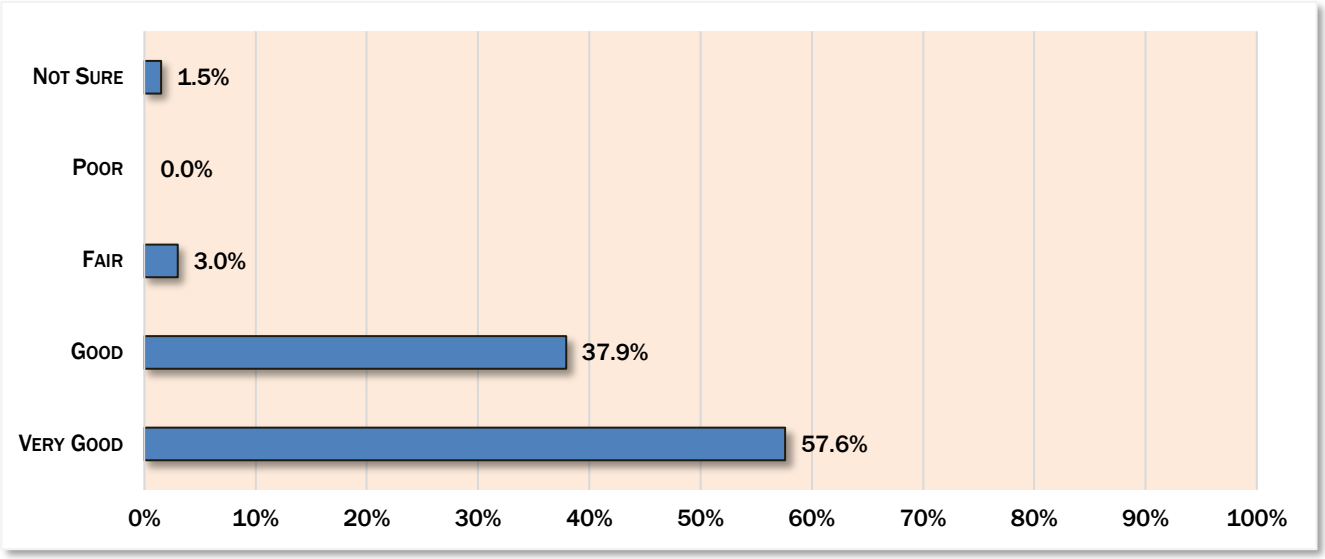
Key Subgroup Findings

- Approximately two-thirds (67.6%) of white respondents (n=309) reported their health was good or very good compared with slightly more than one-half (51.9%) non-white respondents (n=54). This difference was statistically significant ($p < .01$).

- Almost 90 percent (86.1%) of respondents reporting an annual household income of $90,001 and higher (n=78) reported that their health was good or very good, which was statistically higher compared with two-thirds of respondents reporting an annual household income of $60,001 to $90,000 (67.1%, n=70). The same was true for respondents between $30,001 to $60,000 (64.9%, n=95), and respondents reporting an annual household income of $30,000 and less (42.2%, n=81) – $p < .001$).

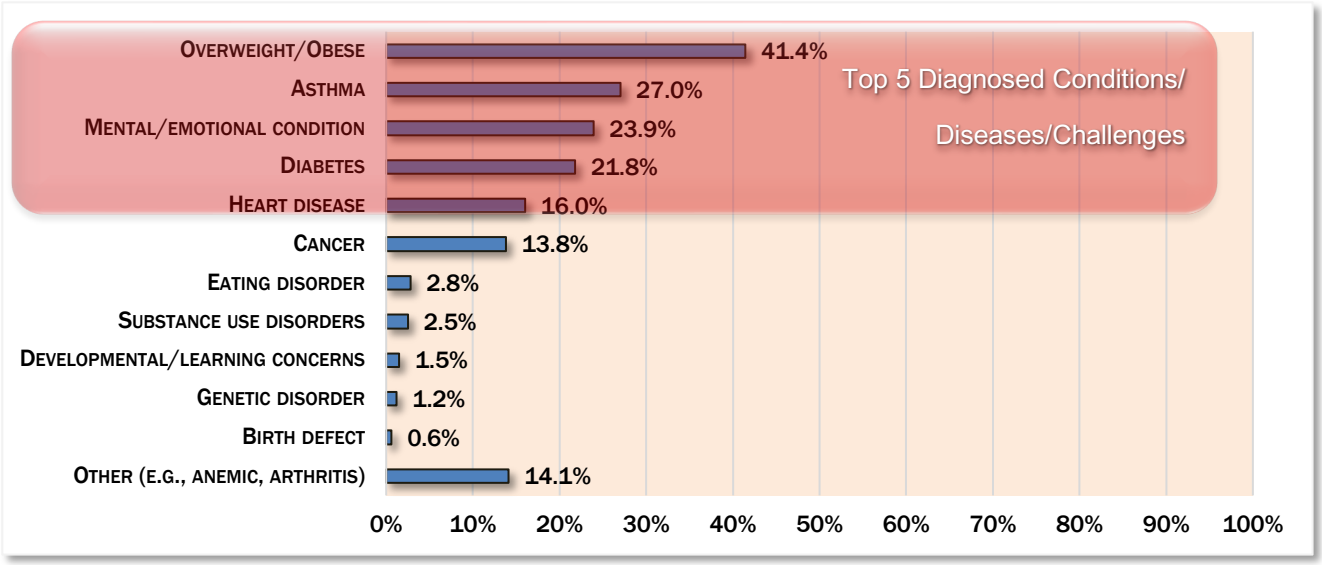
Overall Health of Respondents' Child(ren) Under the Age of 18: Respondents completing the Community Health Needs Assessment (CHNA) Survey were asked to describe the overall health of their child(ren) using the following categorical response set: Very Good, Good, Fair, Poor, and Not Sure. The percentage of respondents for each category of the response set is reported in Figure 10. Almost all (95.5%) of respondents reported the overall health of their child(ren) as good or very good.

Figure 10: Overall Health of Respondents' Child(ren) Under the Age of 18 (N=66)



Respondents With Diagnosed Health Conditions: Respondents completing the survey were asked if they had been diagnosed by a doctor or health care professional with the any of the conditions, diseases, or challenges identified in Figure 11. The top (5) five diagnosed conditions, diseases, or challenges were: 1) overweight/obese; 2) asthma; 3) mental/emotional condition; 4) diabetes; and 5) heart disease.

Figure 11: Respondents with Diagnosed Health Conditions (N=326)



Other Key Findings

- Approximately one-third (31.6%) of male respondents (n=79) reported they had been diagnosed with diabetes compared with 19.1% of female respondents (n=241). This difference was statistically significant ($p < .05$).

- One-quarter (25.3%) of male respondents (n=79) reported they had been diagnosed with heart disease compared with 13.3% of female respondents (n=241). This difference was statistically significant ($p < .05$).

- 14.5% of respondents reporting an annual household income of $90,001 and greater (n=62) reported that they had been diagnosed with a mental emotional condition, which was statistically higher compared with respondents reporting an annual household income of $30,000 and less (37.0%, n=73) – $p < .001$.

- Of the respondents that reported that had been diagnosed with a mental/emotional condition; in the previous year, 60.0% reported using counseling/therapy services, 44.6% reported using psychiatric medications, and 27.7% reported using behavioral health/mental health clinic services (N=65).

Respondents' Child(ren) Under the Age of 18 with Diagnosed Health Conditions: Respondents completing the survey were asked if their child(ren) had been diagnosed by a doctor or health care professional with any conditions, diseases, or challenges listed in Figure 11. The top three (3) diagnosed conditions, diseases, or challenges were: 1) asthma, 34.5%; 2) developmental/learning concern, 18.2%; and 3) mental/emotional condition 16.4% (N=55).

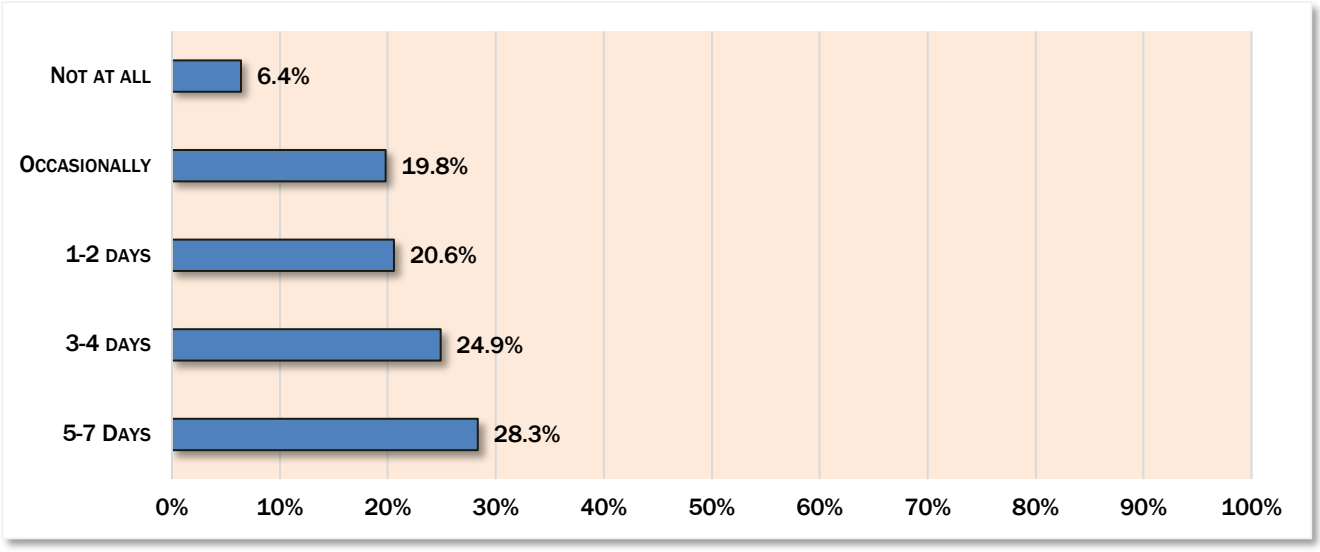
Other Key Findings

- Of the respondents that reported their child(ren) had been diagnosed with a mental/emotional condition; in the previous year, 90.9% reported that their child(ren) used counseling/therapy services, 45.5% reported their child(ren) used behavioral health/mental health clinic services, and more than one- quarter (27.7%) reported their child used psychiatric medications (N=65).

Exercising Habits of Respondents[3]:
Respondents completing the Community Health Needs Assessment (CHNA) Survey were asked how many days a week, on average, they completed 30 minutes of exercise or other physical activity (e.g., walking, running, gardening using the following categorical response set: Not at all, only occasionally, 1 to 2 days, 3 to 4 days, 5 to 7 days. The percentage of respondents for each category of the response set is reported in Figure 12. More than one-half (53.2%) of respondents reported that they completed 30 minutes of exercise or other physical activity at least three (3) days a week.

The number one (1) obstacle reported by respondents that prevents them from getting regular exercise was "lack of motivation," reported by 44.0% of respondents.

Figure 12: Average Number of Days Each Week Respondents Exercise at Least 30 Minutes (N=374)

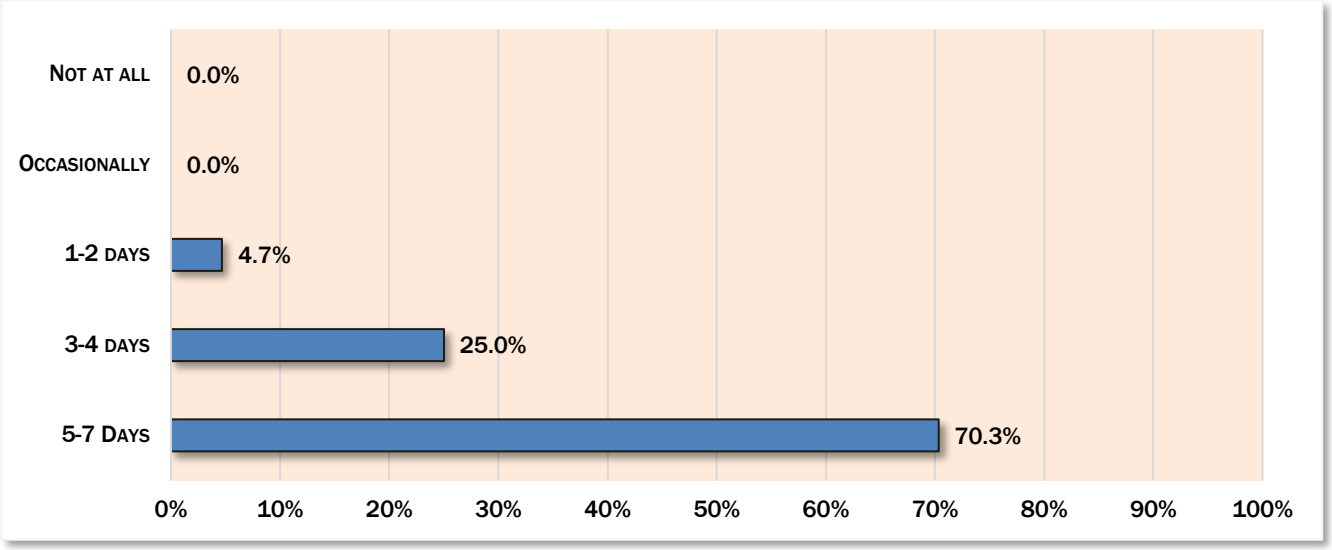


[3]For substantial health benefits, adults should do at least 150 minutes (2 hours and 30 minutes) to 300 minutes (5 hours) a week of moderate-intensity, or 75 minutes (1 hour and 15 minutes) to 150 minutes (2 hours and 30 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic activity. Preferably, aerobic activity should be spread throughout the week.

Source: U.S. Department of Health and Human Services. Physical Activity Guidelines for Americans, 2nd edition. Washington, DC: U.S. Department of Health and Human Services; 2018.

Exercising Habits of Respondents' Child(ren) Under the Age of 18[4]: Respondents completing the Community Health Needs Assessment (CHNA) Survey were asked how many days a week, on average, their children completed 30 minutes of exercise or other physical activity (e.g., walking, running, gardening) using the following categorical response set: Not at all, only occasionally, 1 to 2 days, 3 to 4 days, 5 to 7 days. The percentage of respondents for each category of the response set is reported in Figure 13. Ninety-five percent (95.3%) of respondents reported that their child(ren) completed 30 minutes of exercise or other physical activity at least three (3) days a week.

Figure 13: Average Number of Days Each Week Respondent's Child(ren) Exercise at Least 30 Minutes (N=64)



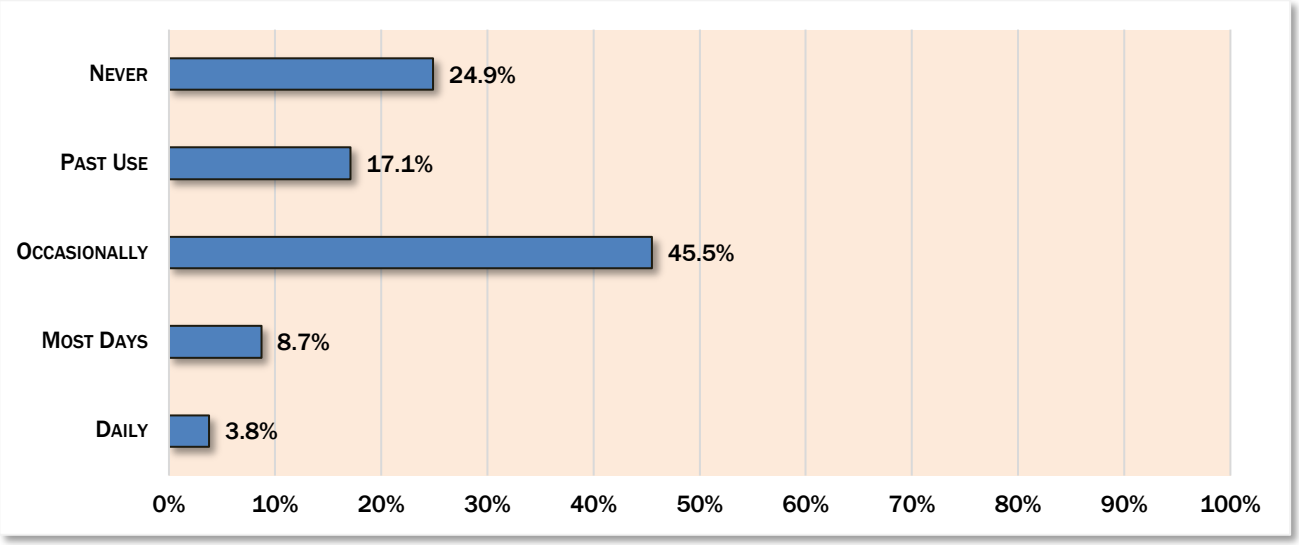
Substance Use[5]: Alcohol: Respondents were asked to describing their alcohol use utilizing the following categorical response set: Never, Past Use, Fair, Occasionally, Most Days, and Every Day. The percentage of respondents for each category of the response set is reported in Figure 14. Nearly 60 percent (58.0%) of respondents reported using alcohol at least occasionally.

[4]Preschool-aged children (ages 3 through 5 years) should be physically active throughout the day to enhance growth and development. Children and adolescents ages 6 through 17 years should do 60 minutes (1 hour) or more of moderate-to-vigorous physical activity daily.

Source: U.S. Department of Health and Human Services. Physical Activity Guidelines for Americans, 2nd edition. Washington, DC: U.S. Department of Health and Human Services; 2018.

[5] Less than 10 percent (9.4%) of respondents reported currently smoking (N=359). Two percent (2.2%) of respondents reported currently using electronic cigarettes (N=369). Two percent (1.9%) of respondents reported currently using cigars, chew, and/or snuff (N=370).

Figure 14: Using Alcohol (N=369)



Other Key Findings

- Eighty percent (80.8%) of respondents reporting an annual household income of $90,001 and greater (n=78) reported using alcohol at least occasionally, which was statistically higher compared with respondents reporting an annual household income of $30,000 and less (43.0%, n=79) – $p < .001$.

Assessing Health Care Issues

Access to Quality Health Care: Respondents were asked to respond to the question "Do you feel that you have adequate access to quality health care?" using the following scale (which has been reversed for this report): 1 = Never; 2 = Rarely; 3 = Sometimes; 4 = Often; and 5 = Always. The mean (average) score for the question, 3.70, suggests that, overall, respondents reported that they "sometimes" have adequate access to quality health care. The percentage of respondents for each category of the response set is reported in Figure 15. More than one-half (56.9%) of respondents reported that they "often" or "always" have adequate access to quality health care.

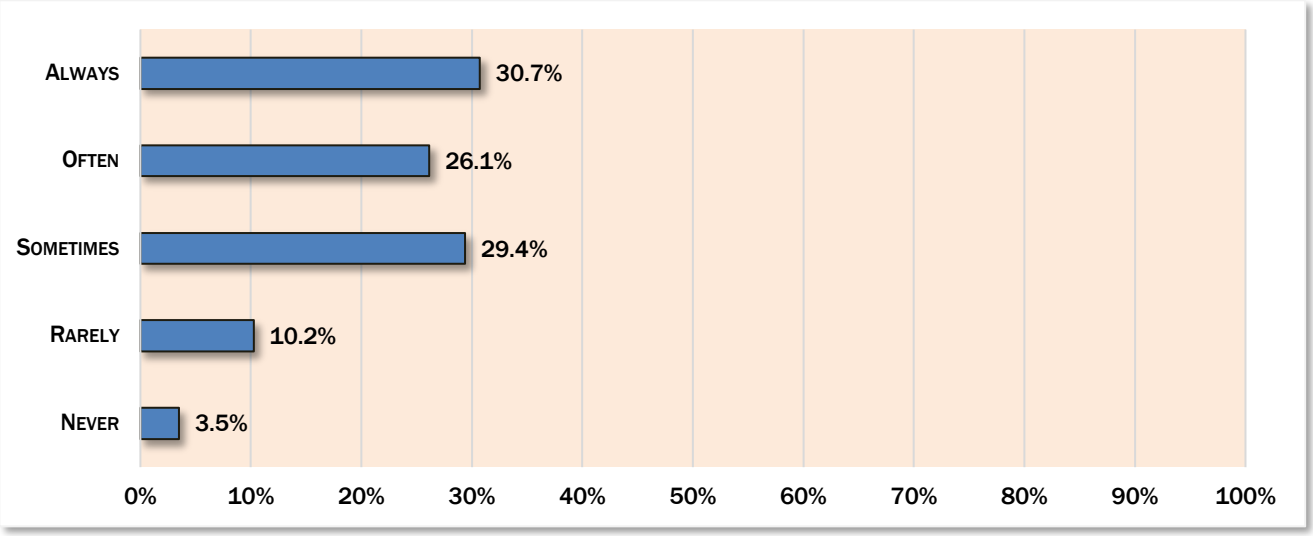
For those respondents that reported having inadequate access to health care, the top three (3) reasons that health care access was inadequate was:

1) Long wait times

2) Lack of specialty doctors

3) Doctors not accepting new patients

Figure 15: Adequate Access to Quality Healthcare (N=371)



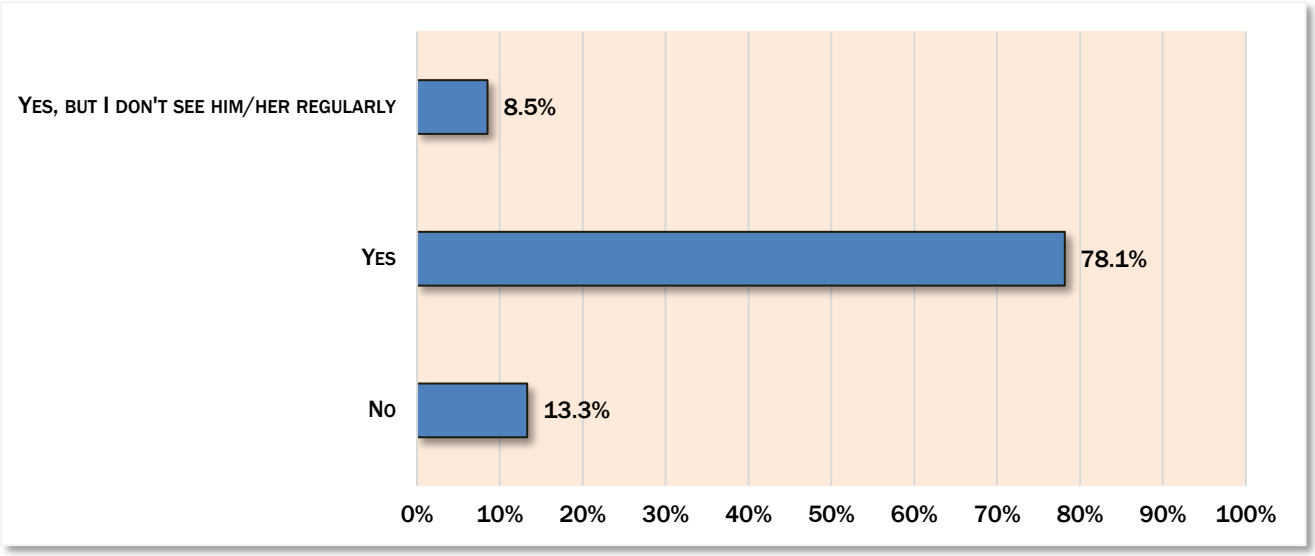
Other Key Findings

- Two-thirds of respondents with an annual household income of $90,001 and higher (66.2%, n=78) and two-thirds of respondents with an annual household income of $60,001 to $90,000 (65.7%, n=70) reported that they "often" or "always" had adequate access to health care. The percentage of respondents reporting an annual household income of $30,000 and less (42.0%, n=81) who reported that they "often" or "always" had adequate access to health care was statistically lower compared with respondents reporting an annual household income of $90,001 and higher and respondents reporting an annual household income of $60,001 to $90,000 – $p < .05$. For those respondents that reported they had adequate access to health care services sometimes, rarely, or never, the top three (3) reasons[6] that supported their response were 1) long wait times, 25.8%; 2) lack of specialty doctors, 21.2%; 3) doctors not accepting new patients, 20.5%.

Having a Primary Care Physician: Respondents were asked if they had a primary care provider (PCP) [that they saw regularly] using the following response set: Yes, No, and Yes, But I Don't See Him/Her Regularly. The percentage of respondents for each category of the response set is reported in Figure 16. More than three-quarters (78.1%) of respondents reported that they had a PCP that they saw regularly.

[6]The response sets from which respondents could choose their 1st choice, 2nd choice, and 3rd choice all included the following response choices: *transportation, cost, long wait times, cultural/language barriers, lack of specialty doctors, inadequate or no insurance, doctors not accepting new patients, and other.* The number of times each response set category choice (e.g., transportation, lack of specialty doctors) was selected as a 1st choice, 2nd choice, and 3rd choice were totaled (numerator) and divided by the number of total selections (denominator) made by respondents. For example, there were 396 selections made by respondents responding sometimes, rarely, and never to the question, "Do you feel that you have adequate access to quality health care?" for their 1st choice, 2nd choice, and 3rd choice. One-hundred-two (102), or 25.8%, of the 396 total selections was for the choice of *long wait times*.

Figure 16: Having a PCP (N=375)

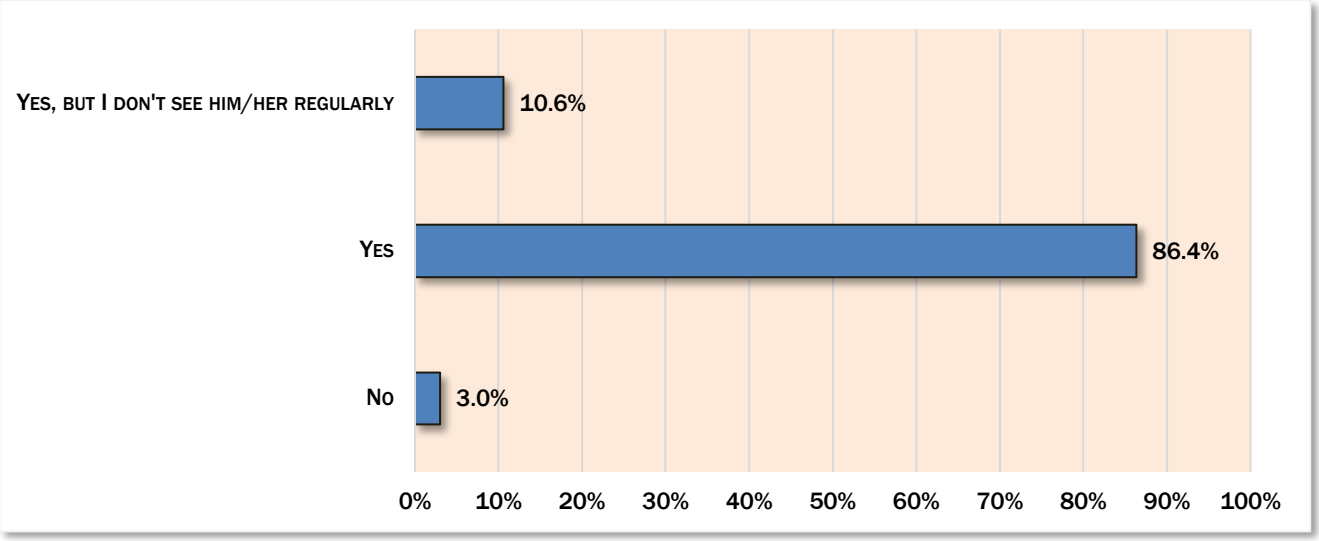


Other Key Findings

- 85.9% of male respondents (n=92) reported that they had a PCP they saw regularly compared with 75.6% female respondents (n=275). This difference was statistically significant ($p < .05$).
- 79.9% of white respondents (n=309) reported that they had a PCP they saw regularly compared with 63.5% non-white respondents (n=52). This difference was statistically significant ($p < .01$).
- 81.3% of respondents without children (n=304) reported that they had a PCP that they saw regularly compared with 62.1% respondents with children (n=66). This difference was statistically significant ($p < .005$).

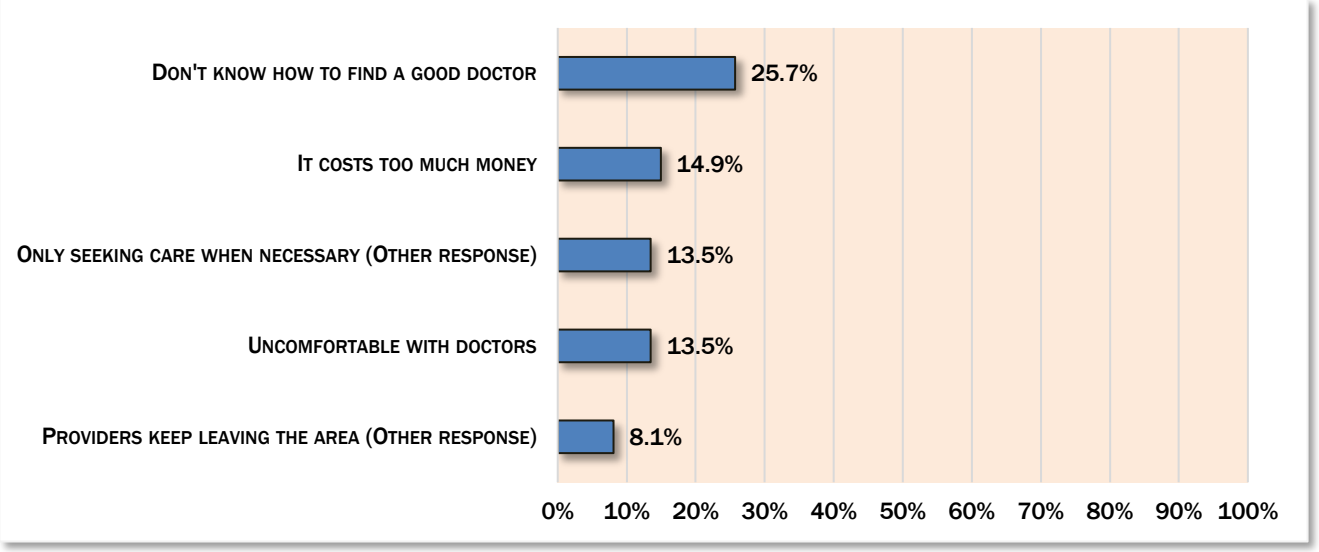
Having a Primary Care Physician for Child(ren) Under the Age of 18: Respondents were asked if their child(ren) had a primary care provider (PCP) [that they saw regularly] using the following response set: Yes, No, and Yes, But They Don't See Him/Her Regularly. The percentage of respondents for each category of the response set is reported in Figure 17. Almost 90 percent (86.4%) of respondents reported that their child(ren) had a PCP that they saw regularly.

Figure 17: Respondents' Child(ren) Under the Age of 18 Having a PCP (N=66)



Top Reasons for Not Having a PCP: Respondents were asked to indicate the reason(s) why they did not see a PCP regularly. The top five (5) reasons are reported in Figure 18. One-quarter (25.7%) of respondents reported that they did not know how to find a good doctor.

Figure 18: Top Five (5) Reasons for Not Having a PCP (N=74)



Seeing a Specialist: Approximately 40 percent (41.0%) of respondents reported that they visit a medical specialist regularly (N=327).

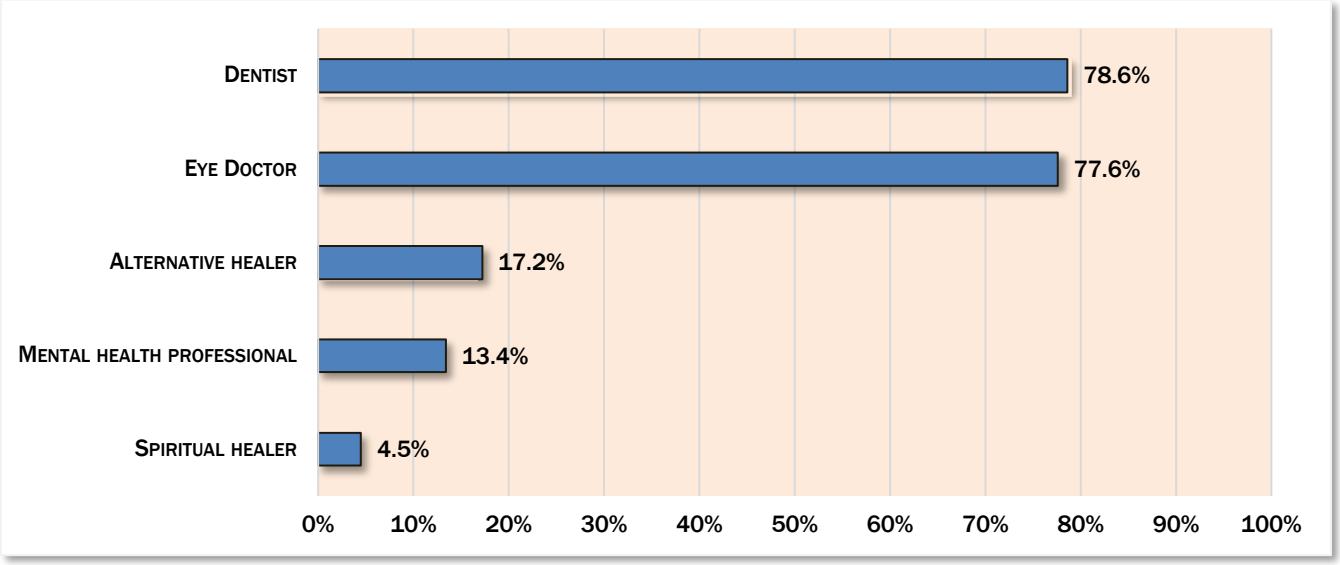
Other Key Findings

- 52.9% of male respondents (n=78) reported that they visit a medical specialist regularly compared with 37.0% female respondents (n=243). This difference was statistically significant ($p < .05$).

- 44.4% of respondents without children (n=266) reported that they visit a medical specialist regularly compared with 24.6% respondents with children (n=57). This difference was statistically significant ($p < .001$).

Specialty Providers Utilized For Care: The top five (5) specialty providers utilized by respondents that regularly visit a specialist are reported in Figure 19. Approximately three-quarters of respondents regularly visiting specialty providers reported regularly visiting a dentist and regularly visiting an eye doctor.

Figure 19: Top Five (5) Specialty Providers Utilized for Care (N=134)



Other Key Findings

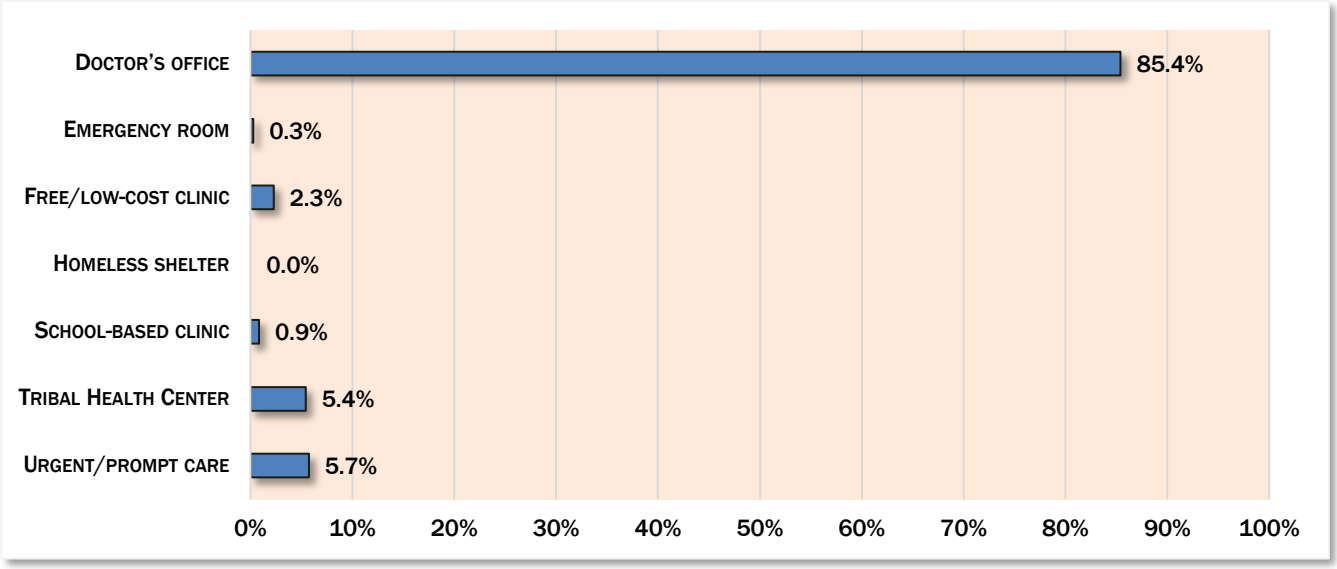
- 2.3% of male respondents (n=41) reported that they visit a mental health professional regularly compared with 17.2% female respondents (n=91). This difference was statistically significant ($p < .05$).

- 10.5% of respondents without children (n=120) reported that they visit a mental health professional regularly compared with 35.7% respondents with children (n=14). This difference was statistically significant ($p < .05$).

- 93.5 of respondents reporting an annual household income of $90,001 and greater (n=31) reported that they visit a dentist regularly, which was statistically higher compared with respondents reporting an annual household income of $30,000 and less (60.0%, n=20) – $p < .05$.

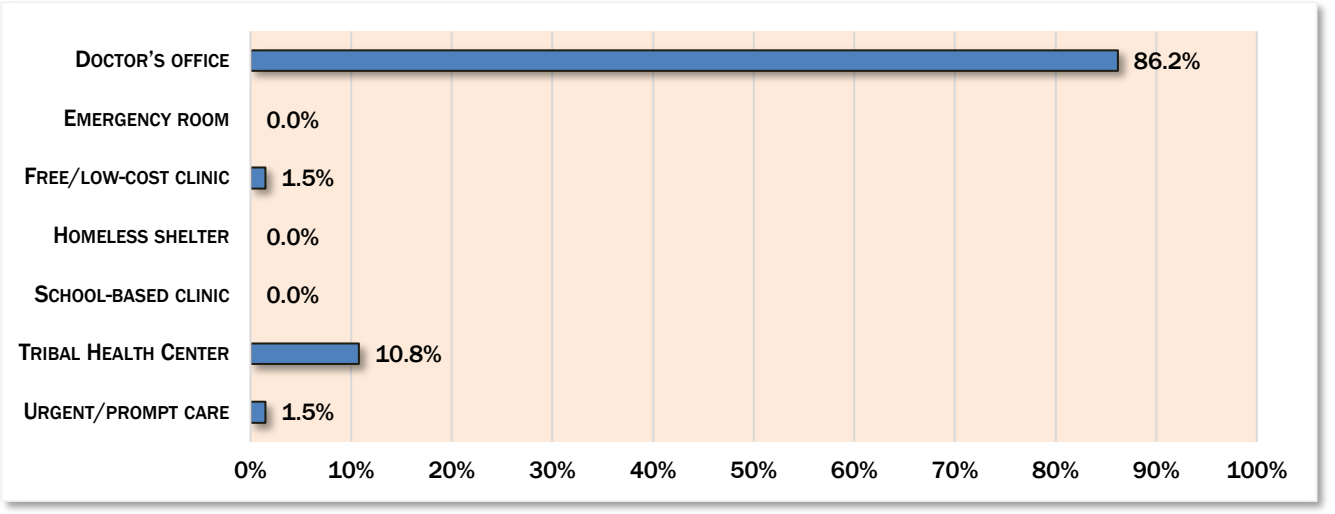
Where Receiving Routine Health Care: Respondents were asked indicate where they received health care.[7] The percentage of respondents for each type of health care facility utilized is reported in Figure 20. Eighty-five percent (85.4%) of respondents reported they receive their routine health care at a doctor's office.

Figure 20: Where Respondents Receive Routine Health Care (N=350)



Where Child(ren) Under the Age of 18 Receive Routine Health Care: Respondents were asked indicate where their child(ren) received health care. The percentage of respondents for each type of health care facility utilized is reported in Figure 21. Eighty-six percent (86.2%) of respondents reported their child(ren) receive routine health care at a doctor's office.

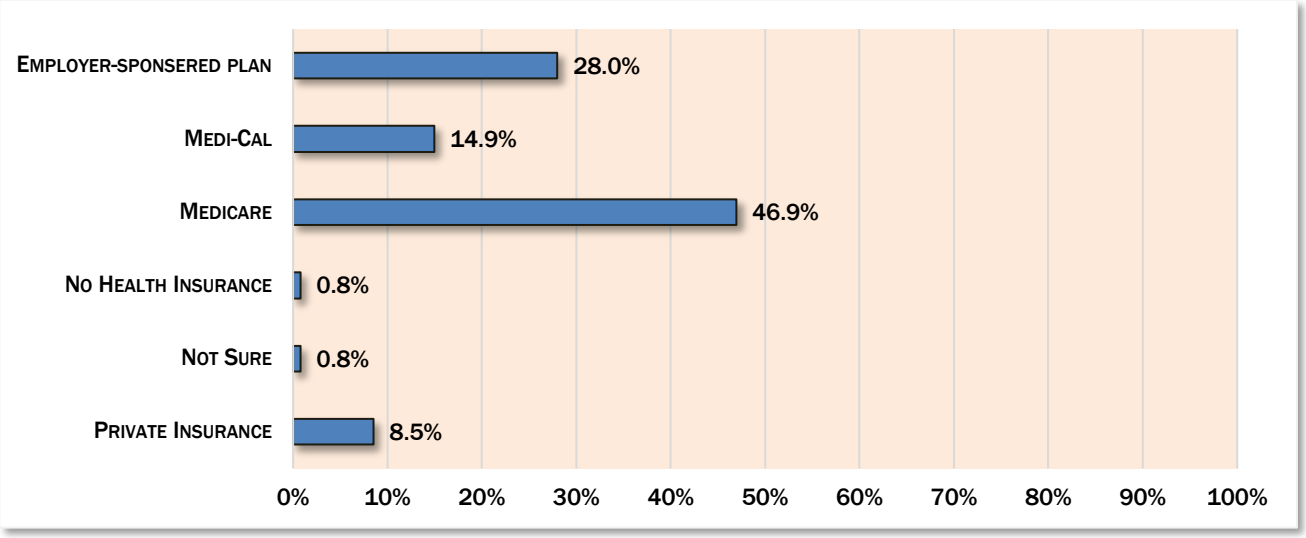
Figure 21: Where Respondents' Child(ren) Under the Age of 18 Receive Routine Health Care (N=65)



[7]Six percent (6.4%) of respondents reported that they receive no routine health care.

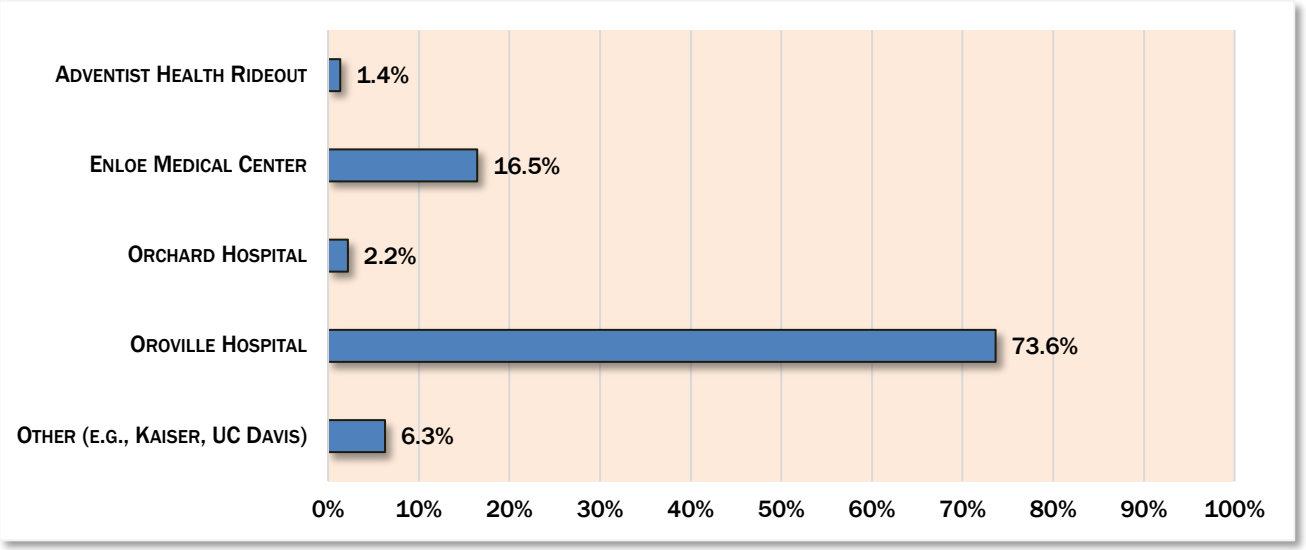
Health Insurance: More than 95 percent (96.6%) of respondents reported that they had health insurance for the entirety of the previous year (N=378). The type of insurance respondents reported currently having is reported in Figure 22. Slightly more than 60 percent (61.9%) of respondents reported that their health care insurance coverage was from Medicare or Medi-Cal.

Figure 22: Respondent's Health Care Insurance (N=375)



Hospital Community Members Typically Go to for Care: The hospital where respondents typically go for their care is reported in Figure 23. Almost three-quarters (73.6%) of respondents reported that they typically go to Oroville Hospital for their care.

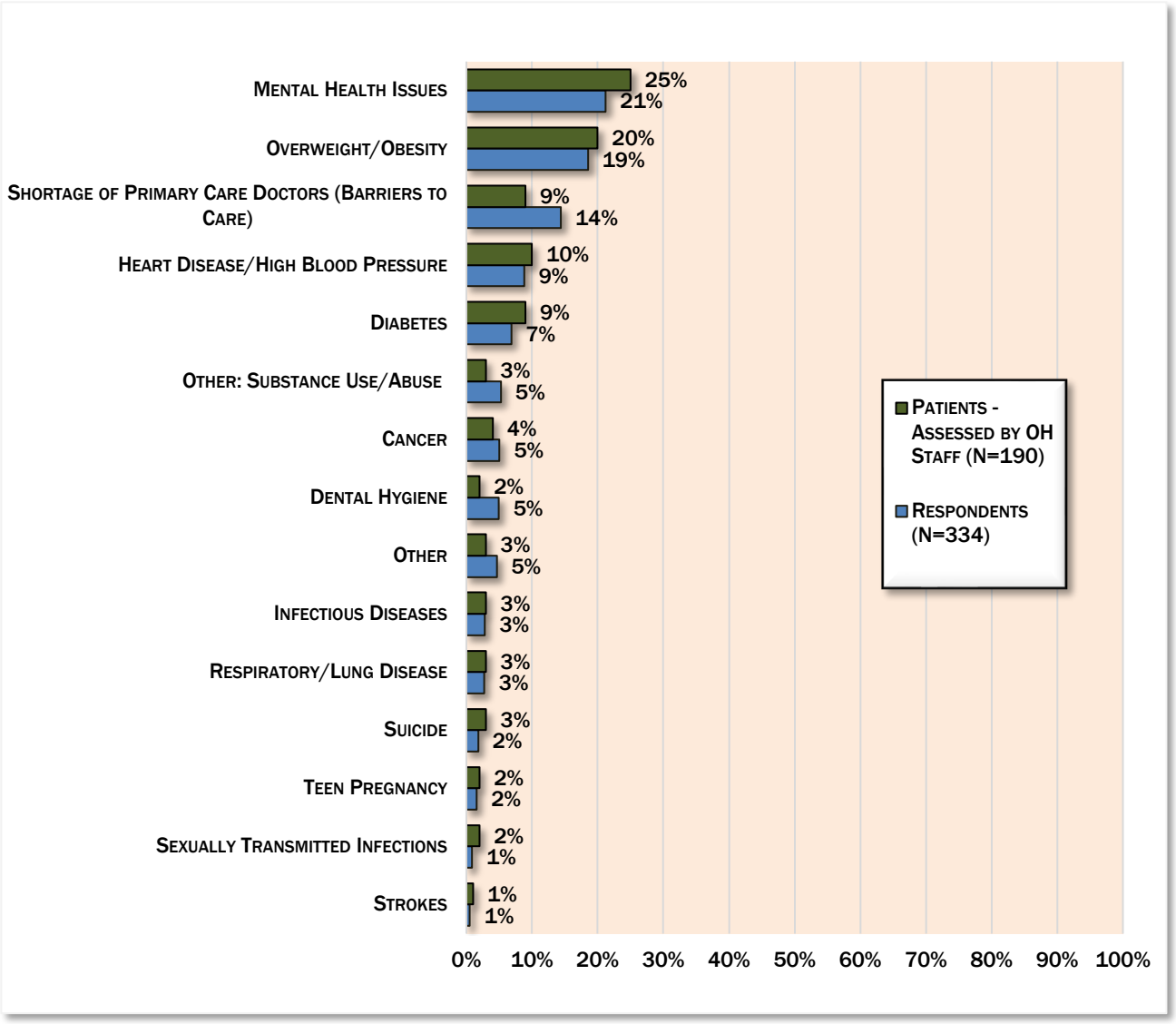
Figure 23: Hospital Where Respondents Typically Go for Care (N=364)



Assessing Concerns/Issues in the Community

The Community Health Needs Assessment (CHNA) asked respondents[8] (i.e., community members) and the Oroville Hospital (OH) employee survey asked employees[9] to assess the greatest health problems facing the community. The health problems are rank-ordered in the Figure 24 below. The top two (2) health problems, mental health issues and overweight/obesity, were identified by respondents and OH employees.

Figure 24: Most Important Health Problems – Respondents and OH Employees

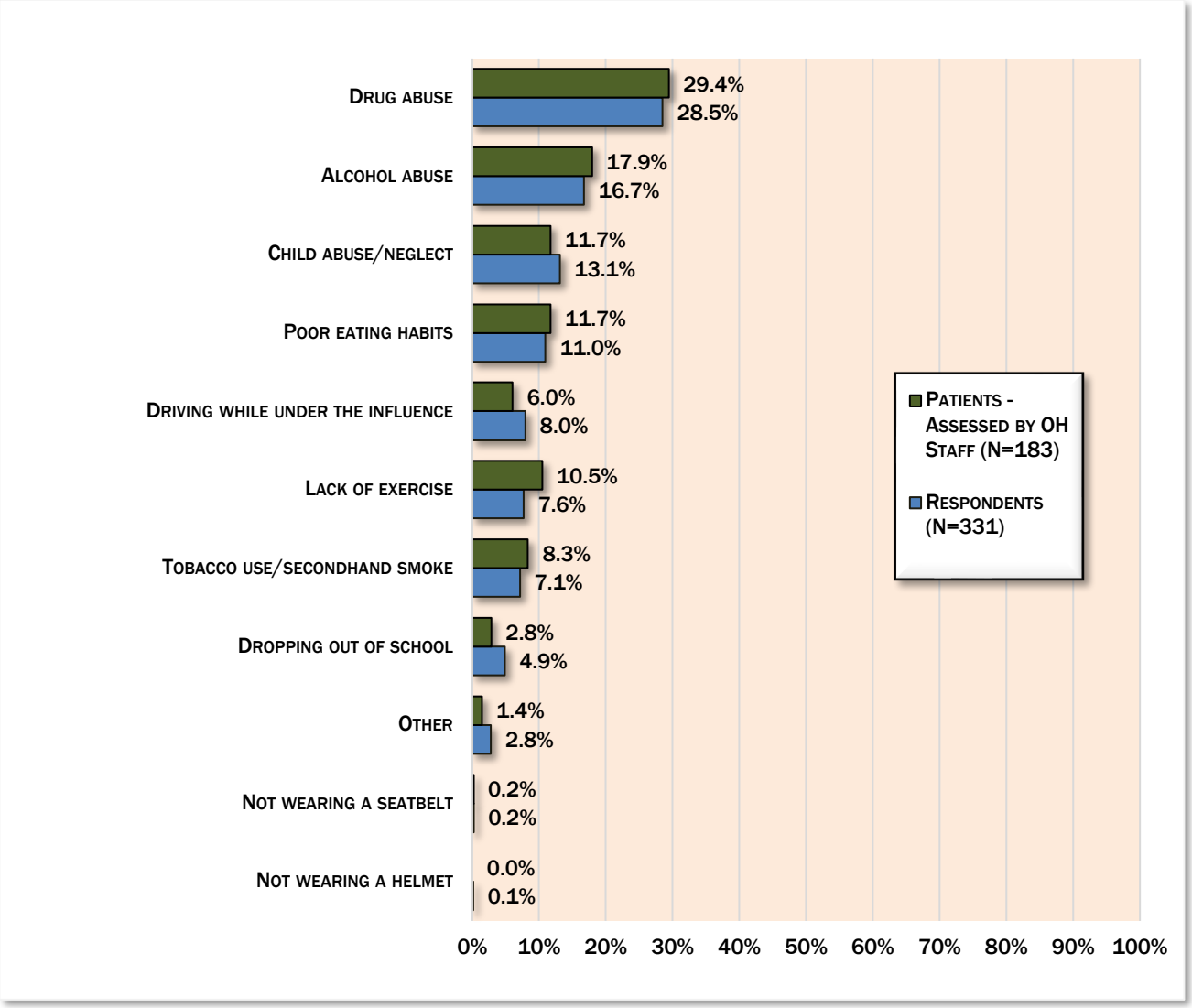


[8]There were 951 selections made by the 334 respondents for their 1st choice, 2nd choice, and 3rd choice.

[9] There were 556 selections made by 190 OH employees for their 1st choice, 2nd choice, and 3rd choice

The Community Health Needs Assessment (CHNA) [10] of community members, and the Oroville Hospital (OH) employee survey asked employees[11] to assess the most challenging risky behaviors facing the community. The risky behaviors are rank-ordered in the Figure 25 below. The top two (2) risky behaviors, drug abuse and alcohol abuse, were identified by respondents and OH employees.

Figure 25: Greatest Need Affecting Children's Health – Respondents and OH Employees



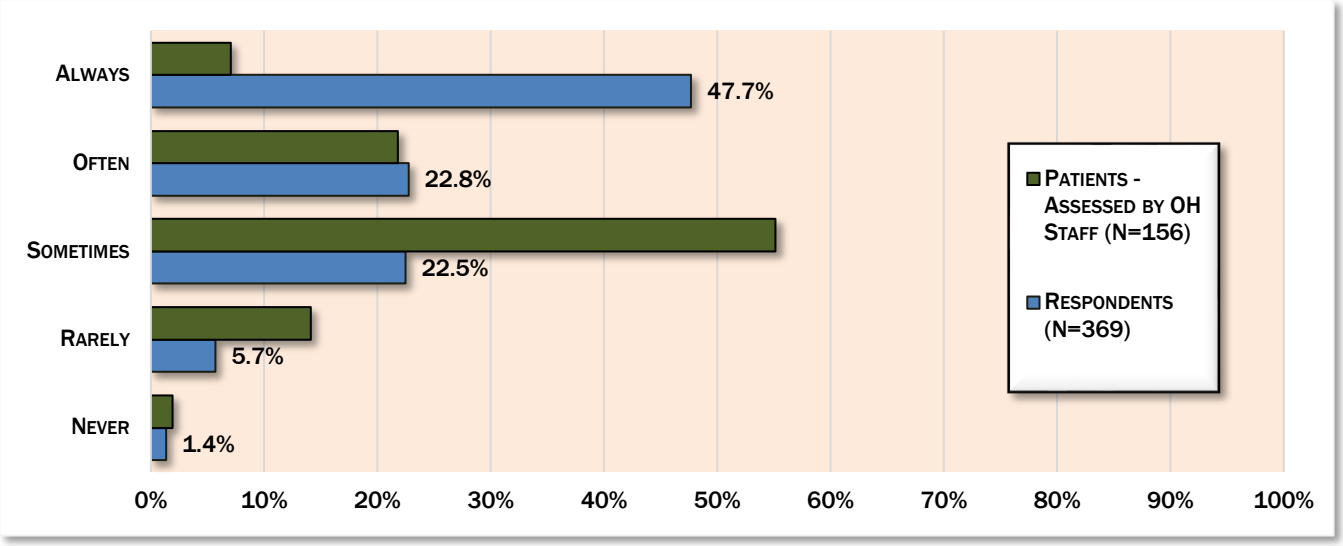
The Community Health Needs Assessment (CHNA) asked respondents to assess how often they had adequate access to affordable and healthy food and the Oroville Hospital employee survey asked employees to assess how often patients had adequate access to affordable and healthy food using the following scale (which has been reversed for this report): 1 = Never; 2 = Rarely; 3 = Sometimes; 4 = Often; and 5 = Always.

[10]There were 968 selections made by the 334 respondents for their 1st choice, 2nd choice, and 3rd choice.

[11] There were 564 selections made by 190 OH employees for their 1st choice, 2nd choice, and 3rd choice

The mean (average) score for community respondents was 4.10, suggesting that overall, respondents "often" have adequate access to affordable and healthy food. The mean (average) score for this item by hospital employee, 3.18, suggests that overall, hospital employee view patients as "sometimes" having adequate access to affordable and healthy food. The percentage of respondents and employees for each category of the response set is reported in Figure 26. Seventy percent (70.5%) of respondents reported that they "often" or "always" have adequate access to affordable and healthy food. Almost 30 percent (28.8%) of OH employees reported that patients "often" or "always" have adequate access to affordable and healthy food.

Figure 26: Frequency of Access to Affordable and Healthy Food – Respondents and OH Employees



Other Key Findings

- Three-quarters of respondents with an annual household income of $90,001 and higher (77.6%, n=77), three-quarters of respondents with an annual household income of $60,001 to $90,000 (75.7%, n=70), and three-quarters of respondents with an annual household income of $30,001 to $60,000 (76.8%, n=795) reported that they "often" or "always" had adequate access to affordable and healthy food. The percentage of respondents reporting an annual household income of $30,000 and less (53.2%, n=81) whom reported that they "often" or "always" had adequate access to affordable and healthy food was statistically lower compared with each of the other household income ranges – a range of $p < .05$. to $p < .005$.

For those respondents that reported they had adequate access to affordable and healthy food only sometimes, rarely, or never, the top three (3) reasons that supported their ranking were: 1) food is too costly, 50.2%; 2) [affordable and healthy food] not available in grocery stores, 19.7%; and 3) not enough time to shop, 6.7%.[12] For those OH employees that reported OH patients had adequate access

[12]The response sets from which respondents could choose their 1st choice, 2nd choice, and 3rd choice all included the following response choices: *too costly, no transportation, cost, not available in grocery stores, not enough time to shop, don't know what*

to affordable and healthy food only sometimes, rarely, or never, the top three (3) reasons that supported their ranking were: 1) food is too costly, 32.9%; 2) patient don't know what to buy, 32.2%; and 3) lack of transportation, 6.7%.[13]

For those respondents that reported having inadequate access to affordable and healthy food was an issue, the top three (3) reasons that access was inadequate was:

1) Food is too costly

2) [Affordable and healthy food] not available in grocery stores

3) Not enough time to shop

For those OH employees that reported patients having inadequate access to affordable and healthy food was an issue, the top three (3) reasons that access was inadequate was:

1) Food is too costly

2) Patients don't know what to buy

3) Lack of transportation

to buy, and other. There were 239 selections made by respondents responding sometimes, rarely, and never to the question, "Do you feel that you have adequate access to affordable and healthy food?" for their 1st choice, 2nd choice, and 3rd choice.

[13]The response sets from which OH employees could choose their 1st choice, 2nd choice, and 3rd choice in regard to patients all included the following response choices: *too costly, lack of transportation, cost, not available in grocery stores, patient do not have enough time to shop, patients don't know what to buy, and other.* There were 239 selections made by respondents responding sometimes, rarely, and never to the question, "Do you feel that patients have adequate access to affordable and healthy food?" for their 1st choice, 2nd choice, and 3rd choice.

Focus Groups and Key Informant Findings

Community Representatives & Leadership Input

Multiple strategies were used to gain insight from members of our community that represent the community as a whole with specific targeting of those that represent the medically underserved, low-income and minority residents. CHNA Focus Groups were carried out at multiple community centers that represented Oroville Hospital's primary medical service area's African American population, the senior citizen (older adult) population, and the Hmong community.

Additionally, a community open forum was held in Oroville at the historic State Theater held where residents from a range of backgrounds and interests attended. This included local health care consumers that have used Oroville Hospital. The purpose these meetings was to elicit input regarding health concerns that are present in our community, and to obtain input on the findings from secondary data analysis. Lastly, community leaders from a range of business, civic and social interests were invited to respond to a series of questions pertaining to the health and well-being of local residents and the role that Oroville Hospital should play to ensure a healthy community. With the advent of COVID-19 fresh in the mind of respondents and its disruption to business as usual, many of the observations for 2022 were comparable to 2019 CHNA findings.

A. Focus Groups

1. African American Family & Cultural Center

Participants agreed that many of the 2019 CHNA health concerns were ongoing issues, and especially in light of COVID-19's interruption in service planning. Health concerns included substance abuse, mental and emotional health, and access to health care services. Additional health concerns that were not addressed in the 2019 CHNA Assessments include the importance of equity, diversity and inclusion, adult education, use of public transportation, and adolescent pregnancies.

Participants stated that they the community would benefit from more affordable adult education programs that give individuals with limited resources the opportunity to gain skills to make them eligible for jobs in the health care field. Participants stated that this would also benefit the African American population by giving them increased opportunity to see individuals with the same cultural background delivering their health care.

Many participants also reported that they were familiar with one or more of the Oroville Hospital sponsored activities, including Oroville Hospital's Farmers' Market, utilization of Butte 2-1-1 referrals, bi-annual health fairs and its Comprehensive Pain and Spine Clinic. Participants responded that among the most beneficial programs was the Farmers' Market, which greatly benefited the community.

2. Feather River Senior Center

Seniors identified several critical health concerns facing the community that had been previously identified in the 2019 CHNA Assessment. This included mental and emotional Health, compounded by COVID-19's isolation, homelessness and poverty, and diabetes among older adults. In addition to

these health concerns, seniors also reported that access to health care and access to healthy and organic foods were important factors that would contribute to healthy diets and lifestyles, and a few reported that they were aware of Oroville Hospital's nutrition counseling program.

Seniors were asked if they have knowledge of Oroville Hospital's actions designed to alleviate the health concerns. Some seniors had heard of Oroville Hospital's Mental Well-Being Clinic, and many had knowledge of utilization of Butte 2-1-1 and had used these services. The Butte 2-1-1 services were also included in the 2019 CHNA Action Plan to address homelessness and poverty.

The majority of the seniors knew about the Farmers' Market and said that it made a positive impact on the community, and recommended that the days of operation should be extended and that shuttles to the market should be made available for those that do not have regular access to transportation.

3. Hmong Cultural Center of Butte County

According to the participants the overwhelming number one concern is access to health care services. The most common restriction that Hmong residents cited when seeking health care is the language barrier for monolingual speakers. Participants stated that this issue seems to create the biggest negative impact when a patient is receiving inpatient hospital care, receiving services from the Comprehensive Pain and Spine Clinic, and when seen by specialty providers' offices. Participants stated that Hmong speaking patients would prefer to have an in-person translator, instead of an interpreter service that are currently being used by telephone. They reported that when the interpreter cannot be seen, they have concerns for the confidentiality of the visit.

Participants suggested identifying providers that speak Hmong in the Oroville Hospital Physician Directory for patients to select a provider that would be best equipped to meet their needs. They also suggested that Oroville Hospital's chaplain coordinate with local shaman to arrange visitation for Hmong patients.

Participants suggested that a support group addressing mental and emotional health, preferably with a Hmong speaking facilitator would be beneficial to the Hmong population, and especially in light of COVID-19.

B. Community Meeting

Open invitations were made for the CHNA Community Meeting at the State Theater in Oroville. Approximately 30 community members participated in the meeting. Among the issues reported were access to health care, emergency department issues, mental and emotional health, and homelessness and poverty.

C. Community Leadership Survey

We received surveys from 17 respondents regarded as leaders by virtue of their service as elected and appointed officials, involvement in community life, business interests, and engagement in the nonprofit sector. The majority of the respondents reported that it is essential for community members to have access to affordable nutritious foods and a safe environment in which they could regularly exercise.

Leaders were asked to envision a health community, among their responses are the following:

- Access to safe recreational areas, nature, and nourishing foods
- General feeling of well-being and cleanliness and access to housing, jobs, services, healthy foods, and parks/recreation areas
- Substantial recreational activities and support programs/resources to address needs of community
- Citizens are physically/mentally healthy [and] stable economy with good wages, health care access, free recreation activities, and sense of belonging to a community
- People are able to work and enjoy life, make healthy decisions on personal health and goals

Among issues cited were homelessness, drug use, the economy, better public transportation, and better wages/jobs. While these issues dominated reported concerns, there were also positive comments made by leaders such as the proximity to outdoor recreation, roadside produce stands, farmers markets, good climate, strong community partners, access to community playgrounds and sports, and relatively affordable housing. Lastly, with regard to gaps in service, among the reported areas were insufficient mental health services for chronically ill persons and detox services.

Secondary Data and Methodology

Secondary data are data and information collected and compiled by other sources and published for use. In this needs assessment, there are two primary sources of secondary data and several secondary sources. The two primary sources, and the data they provided for this report, are:

- 2020 American Community Survey (ACS), five-year average from the US Census Bureau. This is a continuous survey conducted by the Census Bureau with a sample of one of fifty households each year. Thus, the five-year average samples one of every ten households. The ACS provides detailed demographic breakdowns and economic information on households. Released in March 2022, the 2020 data was the latest available when this report was compiled.
- 2020 California Health Interview Survey (CHIS), five-year average from the University of California, Los Angeles. This is an annual survey under contract by state and local public health agencies to collect detailed health and welfare information on California residents. Results are compiled by county with OH consultants running extrapolation and interpolation modeling to create estimates for smaller geographical areas.

ACS and CHIS provided the vast majority of secondary data for this report. Data from these sources are the most recent, reliable, and local that are currently available. Additional data and information were also used from the following sources to fill information gaps or confirm findings from the primary sources:

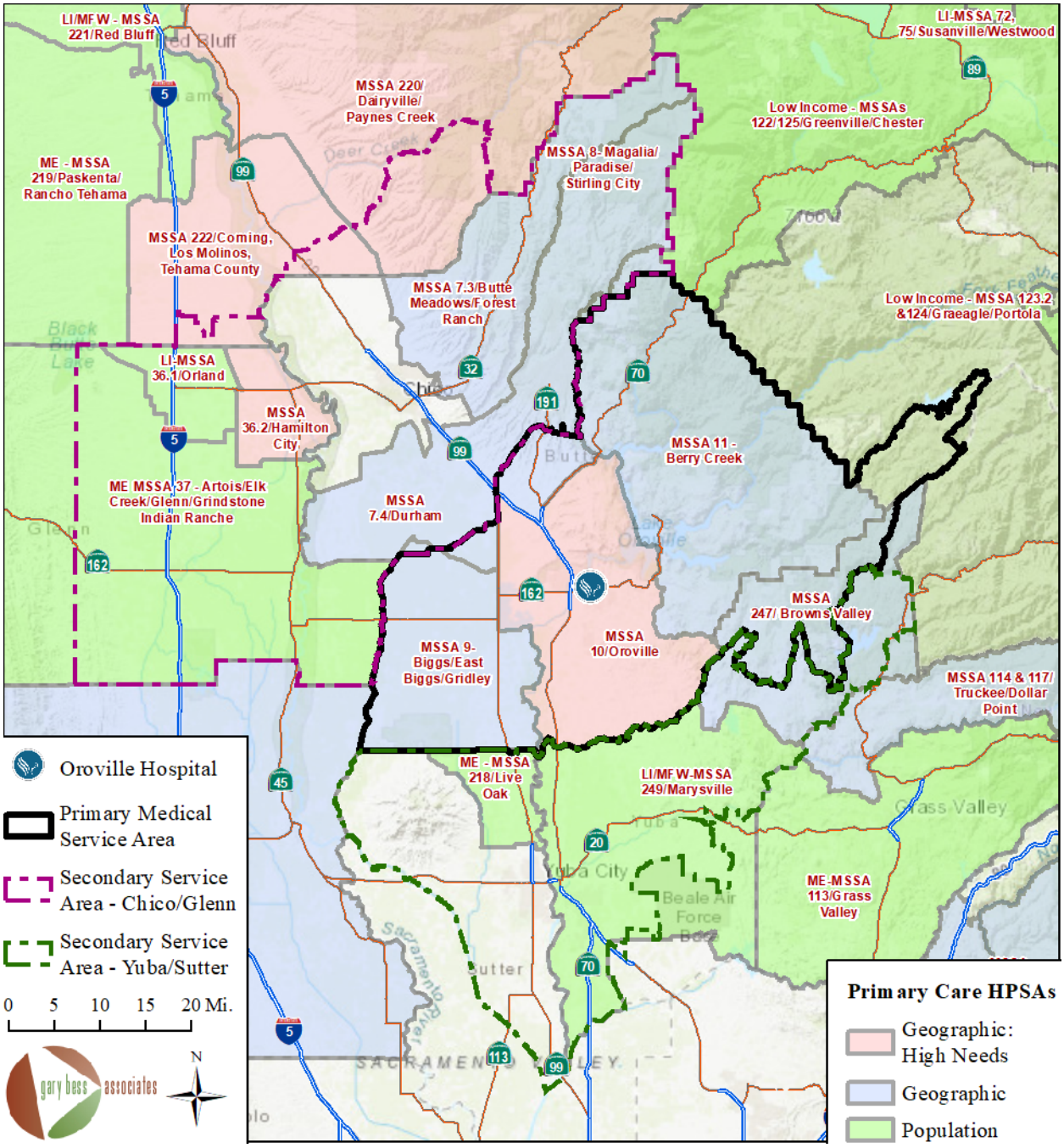
- Butte County Continuum of Care – Homeless point-in-time counts.
- US Department of Health and Human Services, Health Resources and Services Administration – Information and data on Health Professional Shortage Areas
- California Department of Health Care Access and Information, Primary Care Office – Information and updates on Health Professional Shortage Areas and patient discharge data by residential ZIP code to determine Oroville Hospital's Primary Service Area.

- California Department of Health Services, Center for Health Statistics and Informatics – Birth and mortality records with which prenatal and neonatal disparities are calculated, plus age-adjusted mortality by underlying cause specifically for the primary and secondary service areas.

Healthcare Utilization

There are other health care providers in Oroville Hospital's primary and secondary service areas. However, the volume of residents in need of health services exceeds current providers' capacity to provide services. With insufficient primary health care capacity, much of the service area is well-documented as having a shortage of primary health care providers, especially for residents who are low-income or Medi-Cal (Medicaid) eligible. Most parts of both primary and secondary service areas are within one of 12 primary care Health Professional Service Areas (HPSAs). These Federal designations, based on primary care capacity as a result of recent local research conducted by the California Office of Statewide Health Planning and Development, indicate that many residents are economically disadvantaged and may not have access to primary health care (see map below).

Primary Care Health Provider Shortage Areas, Oroville Hospital Service Areas



A hospital that is operating within and/or serves a Health Professional Shortage Area (HPSA) qualifies to apply for additional grant and other funding opportunities that intend to eliminate health access disparities. The primary service area is almost entirely covered in primary care HPSAs. Most of the secondary service areas are also covered in HPSAs, with the exceptions being the Chico and Yuba City areas.

Usual Source of Medical Care: The latest 2020 California Health Interview Survey (CHIS) provides data as to the usual source of medical care reported by residents, which can be disaggregated by household income as a percentage of Federal Poverty Guidelines (FPG). Low-income population estimates were extrapolated for the service area from CHIS data.

More primary service area residents use a community or government-run health center as their usual source of medical care (29.2%), compared with Chico/Glenn (28.7%), Yuba/Sutter (25.8%) or California (23.0%). There were also slightly more persons likely to use an emergency department like Oroville Hospital, or an urgent care clinic (3.3%) than the secondary service area, and much more likely than the state average (2.4%). Notably, residents of the Yuba/Sutter secondary service area were more likely to have no usual source of care (14.1%), when compared with the primary service area, Chico/Glenn, or the state.

Usual Source of Medical Care	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Doctor's Office, HMO, or Kaiser	44,000	56.4 %	61.3 %	56.3 %	56.9 %	167,000	115,000
Community Clinic, Government Clinic, or Community Hospital	23,000	29.2 %	23.0 %	28.7 %	25.8 %	85,000	52,000
Emergency Room, Urgent Care, Some Other Place, or No One Place	3,000	3.3 %	2.4 %	3.2 %	3.2 %	10,000	6,000
No Usual Source of Care	9,000	11.2 %	13.3 %	11.8 %	14.1 %	35,000	28,000
Total Population	78,000	100.0 %	100.0 %	100.0 %	100.0 %	297,000	202,000

Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 5-year average.

Access to Medical Care: Residents of the primary service area had less access to medical care than average in California. Primary service area residents were more likely to have had no routine medical check-up in the past year (32.1%), more likely to only sometimes or never able to get a doctor appointment within two days in the past year when sick or injured (38.8%), and more likely to have had difficulty finding primary care (14.9%), compared with the state average. Primary service area residents were also more likely to have had difficulty finding specialty care (18.5%) compared with the state (13.8%). Delivery of care through telemedicine could be more of a challenge here with Primary Service Area residents being more likely to not use the Internet at least a few times per day (13.7%), yet they were still more likely to receive care through telemedicine (9.6%) because of a lack of other options. Access to care in the secondary service areas was also less than in the state by most measures, although access was less in the Chico/Glenn service area than in the Yuba/Sutter service area.

Access to Medical Care (Ages 18 and Older, Unless Otherwise Specified)	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
No Routine Check-up in the Past year	19,000	32.1 %	27.8 %	31.4 %	27.3 %	75,000	40,000
Only Sometimes or Never Able to Get a Doctor Appt. Within 2 Days in Past year When Sick or Injured (Percent of Those Who Needed Such an Appt.)	28,000	38.8 %	36.6 %	39.5 %	32.0 %	30,000	13,000
Had Difficulty Finding Primary Care	9,000	14.9 %	6.5 %	15.3 %	8.3 %	37,000	12,000
Visited an Emergency Room in the Past Year (2016-18)	16,000	20.0 %	19.4 %	19.7 %	21.9 %	59,000	44,000
Respondent or a Doctor Thinks They Needed to See a Medical Specialist in the Past year	26,000	43.1 %	38.9 %	42.7 %	39.6 %	102,000	58,000
Had Difficulty Finding Specialty Care (Those Who Needed to See a Specialist)	5,000	18.5 %	13.8 %	19.0 %	18.2 %	19,000	11,000
Does not use the Internet at least a few times per day (2019-20), Ages 12+	9,000	13.7 %	11.0 %	13.6 %	12.5 %	35,000	21,000
Received care from health provider through video/phone in past year (2019-20)	6,000	9.6 %	7.8 %	10.0 %	6.9 %	24,000	10,000
Last Mammogram Screening Was More Than 2 Years Ago or Never (Women Ages 40 and Over, 2015-16)	5,000	23.0 %	23.6 %	21.4 %	31.3 %	15,000	14,000

Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 5-year average, unless otherwise specified.

In the primary service area, there are a significant number of non-users and very high users of medical care. Nearly one in five (19.2%) in the primary service area did not have a doctor visit in the past year, and more than one in 20 (5.5%) had at least one visit per month. Both rates are higher than California averages. The secondary service area of Chico/Glenn had usage rates similar to those of the Primary Service Area while the Yuba/Sutter area was closer to the state averages.

Medical Care Utilization in the Past Year	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
No doctor visits	15,000	19.2 %	16.8 %	18.6 %	16.0 %	55,000	32,000
1 to 6 doctor visits	52,000	66.3 %	70.8 %	66.8 %	68.0 %	198,000	137,000
7 -12 doctor visits (high users)	7,000	9.1 %	8.1 %	9.2 %	11.6 %	27,000	24,000
13 or more doctor visits (very high users)	4,000	5.5 %	4.3 %	5.4 %	4.3 %	16,000	9,000
Total population	78,000	100.0 %	100.0 %	100.0 %	100.0 %	297,000	202,000

Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 5-year average.

Overall, more than one in seven primary service area residents (14.9%) either delayed or never received the medical care they needed, and 11.9% delayed or never received medicine prescribed to them. Delaying routine or recommended medical care increase the risk of need for emergency department, surgical, and inpatient hospital visits. The primary reason for delaying medical care was cost or lack of insurance (8.5% of the population). Delay of medical care is also a significant issue in the Chico/Glenn service area, less so in the Yuba/Sutter service area.

Delay of Medical Care	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Delayed or Forgone Needed Medical Care Due to Cost or Lack of Insurance	7,000	8.5 %	5.2 %	8.5 %	6.3 %	25,000	13,000
Delayed or Forgone Needed Medical Care Due to Healthcare System or Provider Issues and Barriers	2,000	2.0 %	2.2 %	2.2 %	1.6 %	7,000	3,000
Delayed or Forgone Needed Medical Care Due to Personal Reasons	3,000	4.4 %	4.5 %	4.4 %	3.5 %	13,000	7,000
Delayed or Forgone Needed Medical Care Due to COVID (2020 only)	2,000	2.5 %	2.6 %	2.4 %	1.1 %	7,000	2,000
Total Delayed or Forgone Needed Medical Care	12,000	14.9 %	11.9 %	15.1 %	11.3 %	45,000	23,000
Those Who Never Received Needed Medical Care	8,000	9.8 %	7.1 %	9.7 %	7.1 %	29,000	14,000
Total Who Delayed or Did Not Get Medicine Prescribed to Them	9,000	11.9 %	8.8 %	11.9 %	12.5 %	35,000	25,000

Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 5-year average, unless

Health Status: Despite issues with health access and utilization, overall health status is not significantly different from the state average among CHIS respondents. Still, more than one in seven residents (15.1%) reported “fair” or “poor” health status. Although previous metrics are better for the Yuba/Sutter area, the reported health status was lower at 17.3% claiming “fair”, or “poor” health status as compared to both the state and the other service areas.

Health Status	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Excellent	19,000	23.7 %	25.4 %	23.7 %	21.2 %	70,000	43,000
Very good	26,000	33.8 %	31.3 %	32.8 %	31.4 %	97,000	63,000
Good	21,000	27.4 %	27.9 %	28.1 %	30.1 %	84,000	61,000
Fair	9,000	11.5 %	12.4 %	12.0 %	12.5 %	36,000	25,000
Poor	3,000	3.7 %	3.0 %	3.5 %	4.9 %	10,000	10,000
Total population	78,000	100.0 %	100.0 %	100.0 %	100.0 %	297,000	202,000
Total fair or poor health status	12,000	15.1 %	15.4 %	15.4 %	17.3 %	46,000	35,000

Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 5-year average.

Internet Access: Increasingly, telehealth over Internet video has become a technologically feasible and cost-effective method for delivering quality health care services. The recent COVID-19 pandemic forced rapid implementation of telehealth. Residents with a hardline broadband Internet subscription and now, with the rollout of 5G transmission, cellular data are the two technologies and subscription factors that ensure reliable access to the quality video required for telehealth. Other services such as dial-up or satellite suffer from bandwidth and latency issues that make quality video difficult or unreliable. Accessing services with a subscription does not guarantee the reliability of a connection, and those with no Internet access at all are most limited by the rollout of telehealth technology. Therefore, anyone who does not have consistent access to broadband or cellular data, cannot be assured reliable access to telehealth should it be needed.

Nearly one-third of all households (32.0%) in the primary service area likely do not have an Internet connection that is sufficiently robust to handle video conferencing. This share is much higher than Chico/Glenn (18.3%), Yuba/Sutter (20.0%), California (14.7%), and the U.S. (18.6%) averages, even though the vast majority of the service area has access to high-speed broadband connectivity. A larger share of households relies on satellite services or a combination of non-broadband services, compared with Chico/Glenn, Yuba/Sutter, or state averages.

Broadband Internet Access	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Broadband subscription (e.g., cable, fiber optic, or DSL)	13,938	54.8 %	75.2 %	70.3 %	71.5 %	62.6 %	49,713	34,139
Cellular data only	3,341	13.1 %	10.1 %	11.1 %	10.1 %	17.4 %	7,049	9,484
Dial-up only	129	0.5 %	0.2 %	0.3 %	0.3 %	0.3 %	177	167
Satellite service only	794	3.1 %	0.6 %	0.6 %	1.3 %	1.0 %	907	554
Some combination of cellular, dial-up, and satellite	2,797	11.0 %	3.0 %	3.1 %	4.5 %	4.7 %	3,122	2,554
Other service or access w/o subscription	735	2.9 %	2.2 %	2.7 %	2.6 %	2.0 %	1,777	1,069
No Internet access	3,685	14.5 %	8.7 %	11.8 %	9.7 %	12.0 %	6,737	6,563
Total households	25,419	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	69,482	54,530
Access likely insufficient for reliable video	4,455	32.0 %	14.7 %	18.6 %	18.3 %	20.0 %	5,983	4,344

Source: U.S. Census Bureau, 2019 American Community Survey 5-Year Estimates, Table B28002.

Economic Factors Associated w/ Health Care Access and Utilization

The previous section documented that access to health care is a challenge for primary service area residents within Oroville Hospital's service area. This section will present factors associated with lack of access and utilization. This includes the economic challenges facing service area residents such as occupation, unemployment, poverty, housing affordability and homelessness, and lack of sufficient medical insurance. These increase the likelihood that their earnings are insufficient to pay for basic needs, including health care.

Unemployment: Primary service area residents are more likely to be either unemployed or not participating in the labor force. Civilian unemployment represents 5.0% of working-age primary service area adults, and when discounting those not participating in the labor market, 6.9% of the labor force (which represents the traditional unemployment rate) was unemployed on average between 2016 and 2020. This is the most reliable service area-specific measure of unemployment. Both of these rates are higher than the state and national averages, and higher than in the Chico/Glenn service area but are similar to rates in the Yuba/Sutter service area. The percentage of residents ages 18-64 who are not participating in the labor force is also higher, making the labor participation rate (72.7%) lower than in the state, nation, and Chico/Glenn service area. Lower labor participation typically indicates challenges with finding employment to the extent that some people stop looking for work.

Civilian Employment Status, Zip Code Service Area, Ages 20-64	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Employed	59,335	67.7 %	73.6 %	75.0 %	71.8 %	68.9 %	30,553	42,354
Unemployed	4,412	5.0 %	4.5 %	3.9 %	4.3 %	5.0 %	1,835	3,101
Not in Labor force	23,946	27.3 %	21.9 %	21.1 %	23.9 %	26.0 %	10,182	16,005
Total Civilians Ages 20-64	87,693	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	42,570	61,460
Labor Participation Rate		72.7 %	78.1 %	78.9 %	76.1 %	74.0 %		
Civilian Unemployment Rate		6.9 %	5.8 %	5.0 %	5.7 %	6.8 %		

Source: U.S. Census Bureau, 2019 American Community Survey 5-Year Estimates, Table B23025.

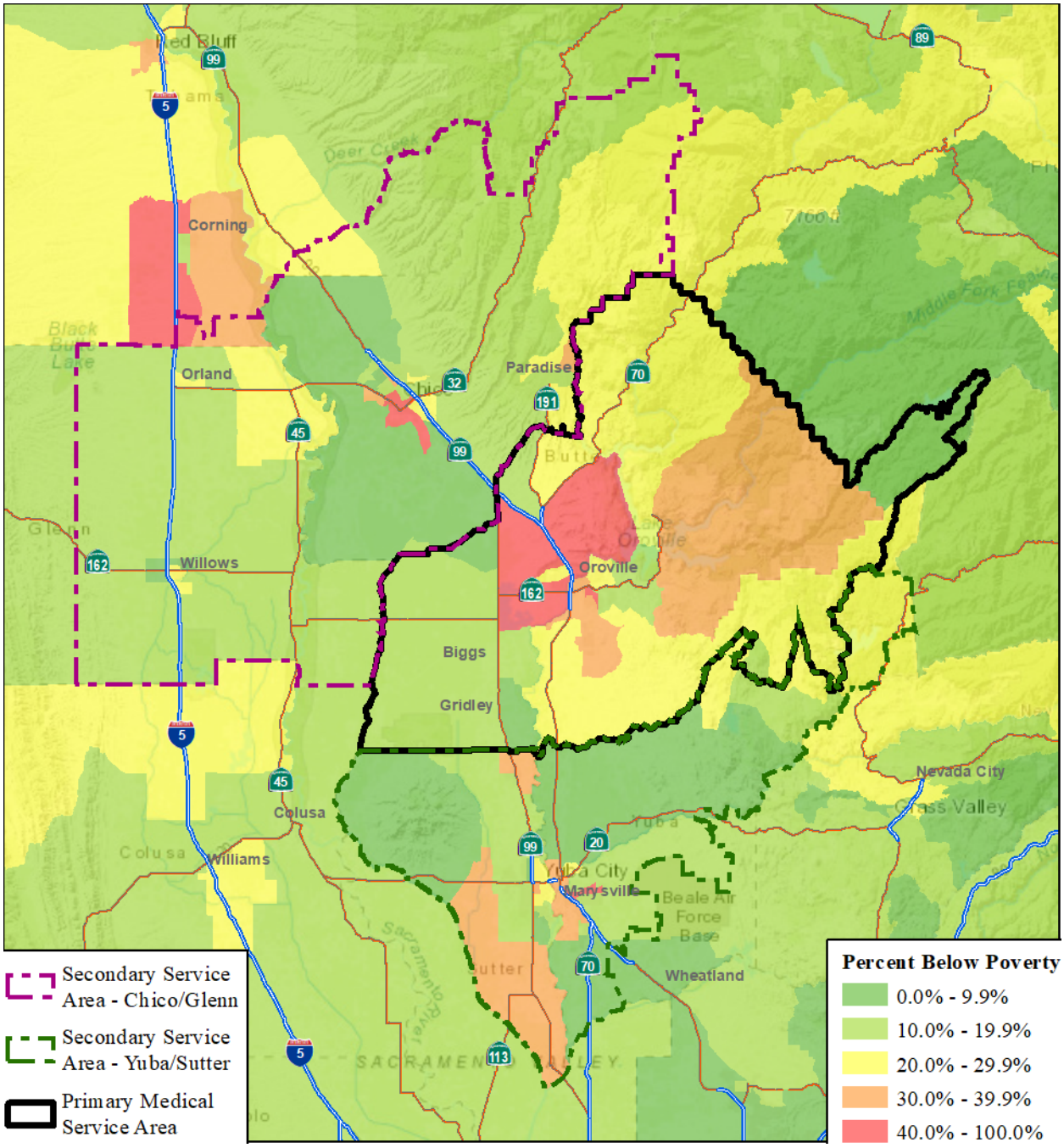
Poverty: Poverty rates in the primary service area (17.7%) are high compared with the state (12.6%) and national (12.8%) averages. This means that the share of residents living below 138% of Federal Poverty Guidelines (FPG), the estimated threshold for income-eligibility for Medi-Cal (28.3%), and the share of residents who are low-income (below 200% FPG, 43.3%) are both much higher as well. Low-income rates in both the Chico/Glenn and Yuba/Sutter service areas are higher than the state/national averages but lower than in the primary service area. The poverty rate for Chico/Glenn is influenced by the concentration of college students in this area.

Income as a Percent of Federal Poverty Guideline (FPG)	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Below 100% FPG	12,370	17.7 %	12.6 %	12.8 %	18.0 %	14.4 %	31,899	22,918
100% to 137% FPG	7,398	10.6 %	6.3 %	6.3 %	6.2 %	7.8 %	10,993	12,384
138% to 199% FPG	10,478	15.0 %	10.5 %	10.7 %	12.4 %	13.6 %	21,956	21,558
200% to 399% FPG	21,577	30.9 %	27.6 %	29.7 %	28.2 %	33.4 %	50,125	53,059
400% FPG and Above	18,108	25.9 %	43.0 %	40.5 %	35.2 %	30.8 %	62,564	48,841
Total Population for whom Poverty Status is Determined	69,931	100.0 %	100.0 %	100.0 %	200.0 %	300.0 %	177,537	158,760
Total Below 138% FPG	19,768	28.3 %	18.9 %	19.1 %	24.2 %	22.2 %	42,892	35,302
Total Below 200% FPG	30,246	43.3 %	29.4 %	29.8 %	36.5 %	35.8 %	64,848	56,860

Source: U.S. Census Bureau, 2019 American Community Survey 5-Year Estimates, Table B17024 and C27016. Some data extrapolated by Gary Bess Associates.

The map below shows the concentration of residents by neighborhood in and around Oroville Hospital's primary and secondary service areas, denoted by orange and red areas. This demonstrates that while the average poverty rate is 17.7% in the primary service area, there are neighborhoods where the concentration of poverty is extremely high (greater than 40% of residents) despite the presence of neighborhoods with relatively low rates (less than 10%). Residents of these areas are among those having the greatest challenge affording and accessing health care.

Low-Income Hot Spots, Oroville Hospital Service Area



Housing Affordability: The cost of housing is an indicator of the overall cost of living since housing is the component with the most variability across geographical areas. While incomes are lower in the service area, so is the cost of housing. Therefore, the best way to measure the cost-of-living challenges using housing cost data is to compare housing costs with income. Comparing home cost with income produces an indicator of housing affordability. The standard affordability threshold used by the U.S. Census Bureau is 30% of income, meaning that households spending more than 30% of income are living in an unaffordable housing situation. Recent increases in housing costs and income, compared

with other costs, may make this threshold too low to measure affordability in 2022, although it remains a comparative indicator of affordability across various locations.

Using this standard, more than one-third of the service area's occupied housing units (34.5%) are unaffordable for their occupants' income. This measure shows that affordability in the Primary Service Area is slightly worse than the national average (30.3%) and slightly better than the state average (40.1%), which would explain why the area experiences both in-migration from other areas of the state and out-migration to areas out-of-state. Affordability is about the same as in the Yuba/Sutter service area and slightly better than in the Chico/Glenn service area. As indicated in the table below, affordability is particularly difficult for renters, with more than one-half (50.3%) of households paying more than 30% of their income on rent. Furthermore, more than one-third of homeowners with a mortgage (35.4%) also have a high unaffordability rate compared with the Chico/Glenn, Yuba/Sutter, and national averages.

Housing Affordability (Number and Percent of Households paying 30% or More of Income on Housing)	Primary SA Occupied Housing Units	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Owner-Occupied Housing Units w/o Mortgage	7,525	1,189	15.8 %	15.0 %	13.1 %	17.2 %	14.3 %	2,690	1,562
Owner-Occupied Housing Units w/ Mortgage	9,414	3,330	35.4 %	37.9 %	27.2 %	32.6 %	33.3 %	7,844	7,180
Renter Occupied Housing Units	8,480	4,262	50.3 %	51.5 %	45.7 %	52.5 %	46.6 %	15,673	10,272
All Occupied Housing Units	25,419	25,419	34.5 %	40.1 %	30.3 %	37.7 %	34.9 %	69,482	19,014

Source: U.S. Census Bureau, 2019 American Community Survey 5-Year Estimates, Tables B2570 and B25091.

Overcrowding: Because housing within the service area is unaffordable for thousands of residents, some choose to combine households to alleviate the cost burden. Overcrowding is defined as households having more than one person per room, with a room defined as an enclosed area not including bathrooms, closets, and garages, but including kitchens, living rooms, dens, lofts, etc. Overcrowding can contribute to poor health because communicable diseases and illnesses are more easily spread in crowded conditions, and in general, it is difficult to keep common areas in the home clean/sanitary when there are many people living within the household. The data shows that overcrowding is a challenge in the primary service area, especially for renters. Overall, 5.9% of occupied housing units are overcrowded, although, for renter-occupied units, more than one in 10 (10.9%) are overcrowded. Generally, overcrowding in the service area is much worse than the national average of 3.3% of units, although not as bad as in California as a whole (8.2%). Overcrowding is about the same in the Yuba/Sutter service area as in the primary service area, although it is less in the Chico/Glenn service area.

Overcrowding (Number and Percent of Households with More Than 1 Person per Room)	Primary SA Occupied Housing Units	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Owner-Occupied Housing Units	16,939	568	3.4 %	4.2 %	1.8 %	1.5 %	4.0 %	604	1,291
Renter Occupied Housing Units	8,480	927	10.9 %	13.2 %	6.2 %	4.2 %	8.0 %	1,247	1,766
All Occupied Housing Units	25,419	1,495	5.9 %	8.2 %	3.3 %	2.7 %	5.6 %	1,851	3,057

Source: U.S. Census Bureau, 2019 American Community Survey 5-Year Estimates, B25014.

Homelessness: Housing challenges are resulting in increasing homelessness across the primary and secondary service areas. The area is challenged by natural disasters that have contributed to both short-term and chronic homelessness in the area, including the 2018 Camp Fire that destroyed nearby Paradise and surrounding communities, the 2020 North Complex Fire that spread through Berry Creek and Feather Falls destroying the vast majority of structures in these communities, and various smaller wildfires that have burned on the periphery of Oroville threatening thousands of homes and destroying dozens. These disasters have compounded an already challenging housing landscape in the primary and secondary service areas with increased numbers of residents camping in public and private spaces

Reliable, consistent counts for this population are challenging because homeless counts are independent for each county and each year, with different count timing and methods for finding, counting, and surveying people found living on streets and in parks and shelters. Methods also vary for interpolating populations not found during counting. All of these methods also vary at least slightly from year to year, although the decrease in the number of homeless counted in 2022 is likely valid as natural disaster victims continue to receive support and get connected with increasing housing opportunities in the county. Still, the impact of the COVID-19 pandemic resulted in somewhat less rigorous efforts than the last full count in early 2019.

In the primary service area, 235 people were counted as homeless in January 2022. They consisted almost entirely of single adults with no children. The age distribution was relatively evenly spread among ages 25 and older, with slightly higher concentrations in ages 35-54. The vast majority were white with a sizeable minority of American Indians. Seventy-six (76) were counted in emergency shelters and transitional housing while 159 were living “unsheltered” in public and private spaces, with or without temporary shelters such as camping tents. There were many more homeless individuals counted in the secondary service areas. The Chico-Glenn service area counted 957 homeless and the Yuba-Sutter service area counted 1,074.

Educational Attainment: Educational attainment in the primary service area is characterized by much lower shares of residents with a bachelor’s degree or higher (14.3%) compared with the state (35.0%) or national (33.3%). Lower educational attainment can often become a barrier to income mobility. However, there is a higher share of residents with some college or an associate’s degree, which suggests that of lack desire for education among residents may not be a barrier. About one in six residents (16.5%) have not graduated from high school, and this is higher than the U.S. (11.2%) and Chico/Glenn (10.1%) averages, while it is lower than the state (15.9%) and Yuba/Sutter (19.3%) averages. The presence of the state university in Chico significantly influences its educational attainment profile.

Educational Attainment	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Less than high school graduate	7,758	16.5 %	15.9 %	11.2 %	10.1 %	19.3 %	11,740	19,786
High school graduate (includes equivalency)	13,677	29.1 %	20.2 %	26.4 %	20.4 %	23.3 %	23,650	23,911
Some college or associate's degree	18,825	40.1 %	28.9 %	29.0 %	37.4 %	38.2 %	43,483	39,219
Bachelor's degree or higher	6,718	14.3 %	35.0 %	33.3 %	32.1 %	19.3 %	37,296	19,832
Total persons age 25+[1]	46,978	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	116,169	102,748

Source: Gary Bess Associates. Estimates derived from U.S. Census Bureau, 2019 American Community Survey 5-Year Estimates, Tables B17003 and B17024.

[1]Population for whom poverty status is determined.

Insurance Status: Medical insurance coverage type is highly correlated to a resident's ability to access health care and can pose a significant barrier. The primary service area is characterized by heavy reliance on Medi-Cal (31.8%) and Medicare (15.0%), coverage rates that are much higher than the state and U.S. averages, and also higher than the Chico/Glenn and Yuba/Sutter service areas. Medi-Cal and Medicare coverage often limits the variety of health providers to which residents can afford to access due to generally lower reimbursement rates compared with private insurance. By comparison, less than one-half (47.0%) of primary service area residents are privately insured, much lower than any comparison area. The share of those not medically insured (6.2%) is lower than any comparison area. Insurance through Covered California, the state's health insurance is categorized as private insurance.

Primary Health Insurance	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Private insurance (incl. purchase through state insurance exchange) or VA coverage	32,945	47.0 %	62.8 %	65.6 %	62.3 %	56.4 %	112,504	89,100
Medicare (incl. Medi-Medi)	10,502	15.0 %	10.1 %	10.9 %	11.2 %	10.4 %	20,131	16,473
Medi-Cal (Medicaid or other means-tested coverage)	22,334	31.8 %	19.9 %	14.8 %	20.1 %	26.2 %	36,305	41,410
None/uninsured	4,364	6.2 %	7.2 %	8.7 %	6.4 %	7.0 %	11,500	11,059
Total noninstitutionalized persons	70,145	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	180,440	158,042
Total Uninsured or on Medi-Cal	26,698	38.1 %	27.1 %	23.5 %	26.5 %	33.2 %	26,698	26,698

Source: Gary Bess Associates. Estimates derived from U.S. Census Bureau, 2019 American Community Survey 5-Year Estimates, Table B27010. Some values extrapolated by Gary Bess Associates.

Two of the primary challenges with current medical insurance is a) cost and b) physicians not accepting their insurance. CHIS provides data concerning the medical insurance and cost challenges reported by residents. Nearly one-half of uninsured primary service area residents indicated that the reason they are not insured is cost (47.7%). Nearly one in 10 (9.2%) report that their medical insurance was not accepted by a general physician, and nearly one in eight (12.1%) indicated that it was not accepted by a specialty physician at some point in the past year. More than one in seven (15.3%) indicated that they had problems paying for their or their household's medical bills in the past year.

Medical Insurance Challenges	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Main reason for currently uninsured status is cost (percent of uninsured).	2,000	47.7 %	41.1 %	50.5 %	52.5 %	10,000	7,000
Medi-Cal eligible (percent ages 18-64 who are uninsured).	1,000	20.7 %	21.2 %	21.2 %	22.6 %	4,000	3,000
Medical insurance not accepted by general physician any time in the past year (ages 18+, percent of medically insured).	5,000	9.2 %	5.3 %	9.4 %	7.4 %	20,000	10,000
Medical insurance not accepted by specialty physician (ages 18+ who needed to see a specialist and were medically insured).	3,000	12.1 %	10.5 %	12.5 %	12.9 %	11,000	7,000
Ever had problems paying for self or household/ family medical bills in past year (ages 18+, 2017-20).	9,000	15.3 %	10.1 %	15.0 %	15.2 %	36,000	22,000
Ever unable to pay for basic necessities due to medical bills (ages 18+, 2017-20).	3,000	4.8 %	3.4 %	4.6 %	6.1 %	11,000	9,000

Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 5-year average, unless otherwise specified.

Prenatal/Neonatal Health Behaviors: Prenatal health care is vital as it contributes to positive health outcomes for the mother and the child. California does much better than the U.S. as a whole concerning prenatal and neonatal disparities. Low birth weight, teen birthmothers, late prenatal care, and pre-term births are much better in the state than in the nation. However, in the primary service area between 2016 and 2020, there were higher rates of births to teen mothers (57.6 per 1,000 live births), and births to mothers who received late prenatal care (316.8 per 1,000), where the mother smoked during pregnancy (125.5 per 1,000) and where the delivery was paid for by public insurance or "self-pay" (usually meaning uninsured, 699.0 per 1,000). These were all higher than both the state and national averages. Late prenatal care and deliveries paid by public insurance or self-pay were also higher in the Yuba/Sutter service area.

Prenatal/Neonatal Health Disparities (Annual Average 2016-2020, Rates per 1,000 Live Births)	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Low birth weight (<2,500g)	52	57.4	69.4	82.5	61.2	69.6	108	157
Teen birthmothers (ages <20)	53	57.6	38.1	48.7	34.9	47.7	61	107
Late prenatal care (first visit after first trimester)	289	316.8	156.6	244.6	218.3	319.7	384	720
Pre-term births (<37 full weeks of gestation, obstetrical estimate)	75	81.7	87.5	100.1	78.8	86.6	139	195
Mother smoked during pregnancy (at least once per day for at least three months)	115	125.5	18.0	68.7	62.2	62.8	110	141
Delivery paid by public insurance or self-pay	638	699.0	486.4	unk.	501.1	581.0	883	1,308
Total births	913						1,761	2,251

Source: Calculated by Gary Bess Associates using California Department of Public Health Master Birth Files and U.S. Census Bureau American Community Survey, 5-Year Average 2016-2020, Table B01001. State, and U.S. data are from Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER Online Database, released October 2021.

Tobacco Use: Smoking and other tobacco use and exposure were higher in the primary service area than average for the state. Nearly one in six (15.9%) are current smokers and 7.0% are current e-cigarette users. More than one-half (51.8%) of adults have claimed exposure to second hand smoke in the past two weeks. Exposure to smoking and tobacco is likely about as high in the Chico/Glenn service area as it is in the primary service area, although it is marginally less in the Yuba/Sutter service area.

Smoking/Tobacco Use (Ages 18 and Older)	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Smoked 100 or More Cigarettes in their Life	24,000	40.0 %	30.3 %	39.2 %	35.6 %	94,000	52,000
Current Smokers	10,000	15.9 %	9.3 %	15.6 %	14.5 %	37,000	21,000
Ever smoked an e-cigarette	13,000	28.5 %	18.5 %	28.3 %	22.4 %	54,000	27,000
Current e-cigarette user (used at least once in last 30 days), (2017-20)	4,000	7.0 %	4.3 %	7.1 %	6.1 %	17,000	9,000
Used flavored tobacco products past month (2018-20)	5,000	8.3 %	6.3 %	8.7 %	8.8 %	21,000	13,000
Ever been exposed to secondhand tobacco smoke or e-cig vapor in California in the last two weeks (2018-20)	31,000	51.8 %	41.1 %	51.7 %	46.9 %	124,000	69,000

Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 5-year average, unless otherwise specified.

Physical Activity: Physical activities that support good health are generally positive in the primary service area, as they are roughly comparable to state averages. The number of children who do not walk or bike to school is higher (73.0%), likely due to the rural landscape of the primary service area and distance to schools, and the lack of non-motor transportation facilities for many residents. Also, people reporting that the nearest park or open space is not within walking distance (17.6%) is higher than in the state for the same reason. These two disparities are also issues in the Chico/Glenn and Yuba/Sutter service areas.

Physical Activity and Access to Parks	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Total Who Did Not Walk, Bike, or Skate Home from School in the Past Week (Ages 0-17 in School, 2016-20)	9,000	73.0 %	61.2 %	72.0 %	68.0 %	28,000	24,000
Three or More Hours Spent on Sedentary Activities on Typical Weekday After School (Ages 2-17)	3,000	19.6 %	32.8 %	22.1 %	31.2 %	11,000	15,000
Five or More Hours Spent on Sedentary Activities on Typical Weekend Days (Ages 2-17, 2016-20)	5,000	31.3 %	30.4 %	30.9 %	41.8 %	16,000	20,000
Did Not Visit Park or Other Open Space in Past Month (Ages 1-17)	6,000	32.7 %	32.3 %	33.0 %	38.3 %	18,000	20,000
Nearest Park or Open Space is Not Within Walking Distance (Ages 1-17)	3,000	17.6 %	9.4 %	21.1 %	15.5 %	11,000	8,000

Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 3-year average, unless otherwise specified.

Diet and Nutrition: Key dietary disparities in the primary service area according to CHIS respondents are daily consumption of fruits and vegetables by youth (especially ages 12-17), and fresh fruits and vegetables not always being available or affordable in their neighborhood. This too may be due to the rural landscape of the primary service area.

Diet	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Eat less than five servings of fruit/vegetables daily (excludes juice and fried potatoes, Ages 2-11)	8,000	62.5 %	66.7 %	64.0 %	75.9 %	24,000	28,000
Eat less than five servings of fruit/vegetables daily (excludes juice and fried potatoes, Ages 12-17)	5,000	86.9 %	72.9 %	83.9 %	75.0 %	17,000	13,000
Less Than 2 Servings of Fruit the Previous Day (Ages 2-17)	3,000	31.5 %	31.7 %	31.4 %	36.8 %	10,000	11,000
Fresh Fruits and Vegetables Not Always Available or Affordable in the Neighborhood (Ages 18+, 2016-18)	12,000	19.2 %	18.5 %	18.5 %	18.4 %	44,000	27,000
Not Always Able to Find Fresh Fruits and Vegetables in the Neighborhood (Ages 18+, 2016-18)	9,000	15.4 %	11.9 %	15.0 %	20.2 %	36,000	30,000
At Least 1 Sugar-Sweetened Sodas Consumed the Previous Day (Ages 2-17)	1,000	12.2 %	21.2 %	13.1 %	22.8 %	4,000	7,000
At Least 1 Sugar-Sweetened Drinks, Other Than Soda, Consumed the Previous Day (Ages 2-17, 2016-18)	3,000	25.7 %	32.0 %	26.8 %	29.1 %	8,000	9,000

Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 5-year average, unless otherwise specified.

Overweight and Obesity: Excessive weight can be a detriment to good health, and while obesity is marginally better in the primary service area compared with the state average, it remains a barrier to a healthier populous. Almost one in seven (13.1%) children under the age of 12 are overweight for their age, which is slightly better than the state average. Nearly two-thirds of primary service area adults are either overweight (32.9%) or obese (28.7%). Obesity is a bigger issue in the Yuba/Sutter service area.

Obesity	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Overweight for Age (Ages 0-11)	2,000	13.1 %	14.3 %	13.2 %	24.1 %	5,000	9,000
Adult BMI <25.0 (Healthy or Underweight)	23,000	38.4 %	38.8 %	37.8 %	36.1 %	90,000	53,000
Adult BMI 25.0 - 29.99 (Overweight)	20,000	32.9 %	33.6 %	33.1 %	31.8 %	79,000	47,000
Adult BMI 30.0 or higher (Obese)	17,000	28.7 %	27.6 %	29.1 %	32.1 %	70,000	47,000
Total Adults	60,000	100.0 %	100.0 %	100.0 %	100.0 %	239,000	147,000

Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 5-year average.

Adverse Health Conditions in the Service Area

As evidenced in this section, residents within the service area are more likely to experience disparities for several critical conditions linked to adverse health outcomes, especially when compared with California. These disparities and contributing factors include asthma, diabetes, heart disease, and hypertension. Each condition is discussed below.

Asthma: Asthma is more common among primary service area residents compared with the state average. More than one in seven (17.2%) have ever been diagnosed with asthma, and 6.3% have had an attack or episode in the past year. Asthma is also a significant disparity in both the Chico/Glenn and Yuba/Sutter service areas. Those who currently have asthma in the Primary Service Area are less likely to not take medicine daily to treat it (57.9%) compared with Chico/Glenn, Yuba/Sutter, and the state.

Asthma (Ages One and Older)	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Currently has asthma and had an attack or episode in the past year	5,000	6.3 %	4.4 %	6.3 %	6.1 %	18,000	12,000
Currently has asthma, no attack or episode in the past year	4,000	5.4 %	4.5 %	5.6 %	5.9 %	16,000	12,000
No longer has asthma, but previously diagnosed	4,000	5.5 %	6.4 %	5.3 %	6.2 %	16,000	12,000
Total ever diagnosed with asthma	13,000	17.2 %	15.3 %	17.2 %	18.2 %	50,000	36,000
Current asthmatics who do not take medicine daily (percent of persons who currently have asthma)	3,000	57.9 %	55.1 %	56.6 %	56.2 %	10,000	7,000

Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 5-year average, unless otherwise specified.

Diabetes: Diabetes tends to be less common among primary service area residents, although it greatly impacts the lives of those who are forced to manage this chronic health condition. About 12,000 primary service area residents have issues with diabetes, having either been diagnosed with it, had it during pregnancy, or have been told by a doctor that they are prediabetic and were asked to make lifestyle changes to thwart the full-on disease. Diabetes is a significant issue in the Yuba/Sutter service area.

Diabetes (Ages 18 and Older)	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Ever Diagnosed with Type II Diabetes	4,000	6.7 %	8.7 %	7.0 %	9.1 %	17,000	13,000
Ever Diagnosed with Other or Unknown Type of Diabetes	1,000	1.2 %	1.5 %	1.2 %	1.7 %	3,000	2,000
Total Ever Diagnosed with Diabetes (Excl. Pregnancy)	5,000	7.9 %	10.2 %	8.3 %	10.7 %	20,000	16,000
Ever Diagnosed with Pregnancy Diabetes (2016-18)	1,000	2.4 %	2.4 %	2.6 %	1.2 %	6,000	2,000
Ever Diagnosed with Pre- or Borderline Diabetes (2016-18)	6,000	9.8 %	15.0 %	9.7 %	15.1 %	23,000	22,000
Total with Diabetes Issues	12,000	20.2 %	25.2 %	20.6 %	27.1 %	49,000	40,000
Less Than "Very Confident" in Controlling or Managing Diabetes (Percent of Those Ever Diagnosed, 2016-18)	2,000	34.8 %	40.8 %	34.2 %	46.3 %	7,000	7,000

Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 5-year average, unless otherwise specified.

Heart Disease and Hypertension: Heart disease diagnosis rates are higher in the primary service area (8.5%) compared with California (6.7%), and while hypertension diagnoses rates (21.2%) are marginally better compared with the state (25.7%), those ever diagnosed with borderline hypertension (10.2% in the primary service area compared with 7.5% in the state) almost completely offsets the difference. However, heart disease and hypertension are significant issues in the Yuba/Sutter service area.

Heart Disease and Hypertension (Ages 18 and Older)	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Total Ever Diagnosed with Heart Disease (2016-20)	5,000	8.5 %	6.7 %	8.5 %	9.8 %	20,000	14,000
Never Provided Heart Disease Management Plan (Percent of Those Ever Diagnosed, 2016-18)	1,000	13.9 %	24.5 %	14.0 %	25.3 %	3,000	4,000
Ever Diagnosed with High Blood Pressure (hypertension)	13,000	21.2 %	25.7 %	21.8 %	24.3 %	52,000	36,000
Ever Diagnosed with borderline hypertension	6,000	10.2 %	7.5 %	10.1 %	5.9 %	24,000	9,000
Does not have someone at doctor's office/clinic who helps coordinate care, Ages 18+ with USC and asthma, diabetes, or heart disease	11,000	22.5 %	25.0 %	22.0 %	24.8 %	11,000	9,000

Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 2-year average, unless otherwise specified.

Factors that Impact Health Care Demand and Delivery

There are several unique needs and characteristics identified within the target population of Oroville Hospital's service area, which may affect health care demand and delivery methods. This section offers a presentation of the unique needs and/or characteristics that may contribute to reduced access to care and/or healthcare utilization within the service area. These unique needs/characteristics include the service area's age profile, transportation challenges, the racial/ethnic and linguistic diversity of the target population, immigration status, environmental issues such as air pollution and housing conditions, and the impacts of adverse childhood experiences among youth raised in the service area.

Age: Age distribution in the primary service area is characterized by a slightly higher proportion of youth (ages 0-17) and a much higher proportion of seniors (ages 65+) and the elderly (ages 75+) compared with the state or national averages. Nearly one-quarter of the population (23.5%) are youth and close to one in five (19.9%) are older ages (65+). The Yuba/Sutter service area is characterized by higher youth populations, while the Chico/Glenn service area has a much higher proportion of college-age (18-24) residents.

Age Distribution	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Ages 0-5	5,504	7.9 %	7.3 %	7.3 %	6.6 %	9.1 %	11,671	14,416
Ages 6-17	10,945	15.7 %	15.5 %	15.4 %	13.5 %	17.5 %	24,039	27,816
Ages 18-24	6,504	9.3 %	8.9 %	8.5 %	14.5 %	8.7 %	25,658	13,780
Ages 25-44	15,506	22.2 %	28.7 %	26.8 %	25.0 %	27.6 %	44,327	43,893
Ages 45-64	17,557	25.1 %	25.1 %	26.0 %	23.2 %	23.2 %	41,115	36,809
Ages 65-74	8,059	11.5 %	8.4 %	9.5 %	10.2 %	8.3 %	18,172	13,115
Ages 75+	5,856	8.4 %	6.0 %	6.5 %	7.1 %	5.6 %	12,555	8,931
Total Population	69,931	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	177,537	158,760
All Children Age 0-17	16,449	23.5 %	22.8 %	22.6 %	20.1 %	26.6 %	35,710	42,232
All Seniors Age 65+	13,915	19.9 %	14.4 %	16.0 %	17.3 %	13.9 %	30,727	22,046

Source: U.S. Census Bureau, 2019 American Community Survey 5-Year Estimates, Table B17024.

Persons assigned female at birth have unique health care needs that impact the demand for obstetrical, gynecological, and other medical services. A lesser proportion of primary service area residents assigned female at birth (30.5%) are of menstruating or child-bearing age. There are higher concentrations of female children and older adults (ages 55+) among primary service area residents compared with the state and national average. As with general age distribution, there are a greater proportion of youth (ages 0-17) in the Yuba/Sutter service area and a greater proportion of college-age females ages 18-24 in the Chico/Glenn service area.

Women (Assigned at Birth) of Child Bearing Age	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Ages 0-11	5,539	15.8 %	14.5 %	14.2 %	12.5 %	16.8 %	11,217	13,261
Ages 12-17	2,619	7.5 %	7.6 %	7.5 %	6.5 %	8.6 %	5,862	6,812
Ages 18-24	2,986	8.5 %	8.7 %	8.2 %	14.5 %	8.1 %	13,021	6,429
Ages 25-34	3,771	10.7 %	14.8 %	13.7 %	13.0 %	15.2 %	11,697	12,048
Ages 35-44	3,945	11.2 %	13.2 %	12.7 %	10.9 %	12.4 %	9,755	9,828
Ages 45-54	4,159	11.8 %	12.9 %	12.9 %	10.6 %	11.5 %	9,530	9,110
Ages 55+	12,127	34.5 %	28.2 %	30.7 %	31.9 %	27.4 %	28,667	21,645
Total	35,146	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	89,749	79,133
Women of likely child bearing age (18-45)	10,702	30.5 %	36.7 %	34.6 %	38.4 %	35.8 %	34,473	28,305
Women of any child bearing age (12-54)	17,480	49.7 %	57.3 %	55.0 %	49.7 %	49.7 %	49,865	44,227

Source: U.S. Census Bureau, 2019 American Community Survey 5-Year Estimates, Tables B17001 and C17002.

Likelihood of Adverse Childhood Experiences: Nearly one-third of children living in the service area (32.3%) are living in situations with a higher probability of linkages with adverse childhood experiences (ACEs). ACEs include household dysfunction caused by mental illness, abuse, substance use, incarceration, and physical and emotional neglect and abuse.

Children living with independent single mothers are the most common members of this group, representing 14.1% of Primary Service Area children and numbering more than 2,300. Another 5.0% children are cared for by their grandparents and 4.7% by a parent or another person at a grandparent's home. In total, more than 5,589 Primary Service Area children (32.3%) live in a situation that may be connected with one or more ACEs. This rate is slightly higher than average in Chico/Glenn, Yuba/Sutter, California, and the U.S.

Youth Ages 0-17 by Person Responsible for Their Care	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Independent married couple/domestic partnership, at least one is a parent	11,304	67.7 %	70.4 %	68.7 %	71.9 %	70.1 %	26,006	30,323
Independent Single Mother	2,360	14.1 %	12.3 %	15.7 %	12.3 %	12.7 %	4,466	5,475
Independent Single Father	727	4.4 %	2.5 %	2.9 %	5.3 %	2.8 %	1,919	1,231
Grandparent(s)	843	5.0 %	3.0 %	3.7 %	2.8 %	2.3 %	1,015	1,014
Parent or other person in Grandparent's home	782	4.7 %	6.3 %	4.4 %	4.2 %	6.5 %	1,521	2,817
Other Relative	518	3.1 %	3.6 %	2.4 %	2.0 %	3.0 %	723	1,315
Nonrelative, Including Foster Children	319	1.9 %	1.7 %	1.8 %	2.3 %	2.3 %	816	1,007
Child in Group Quarters or Homeless	40	0.2 %	0.2 %	0.3 %	0.2 %	0.1 %	84	41
Total Children, Age 0-17	16,701	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	36,176	43,243
Children in home situations linked to higher probability of having experienced adverse childhood experiences (ACEs)	5,589	32.3 %	29.6 %	31.3 %	28.1 %	29.9 %	5,589	5,589

Source: U.S. Census Bureau, 2019 American Community Survey 5-Year Estimates

Race/Ethnic Background and Language: Understanding the racial and ethnic background of its service area residents allows Oroville Hospital to compare the racial/ethnic make-up of its patients with the surrounding community as a measure of equal access to care. It also allows human resources to hire qualified staff who are reflective of the cultural, racial, and linguistic characteristics of the patient population. Patients of diverse races, ethnicities, and cultures can face health disparities unique to them, which challenges Oroville Hospital to identify interventions and treatments that are acceptable. Finally, it allows for targeted cultural competency training for Oroville Hospital staff to improve cultural sensitivity and understanding of cultural beliefs and experiences. Strategies such as these are designed to allow Oroville Hospital to provide the appropriate patient education and outreach, and to reduce or eliminate cultural barriers to receiving care.

While nearly two-thirds of the population in Oroville Hospital's Primary Service Area are non-Hispanic Caucasian (64.4%), all of the major race/ethnic groups are represented in the area, demonstrating a significant amount of ethnic and cultural diversity. About one in five (19.6%) are Hispanic or Latino, 6.9% are Asian (including Hmong, Mien, Lao, Thai, Filipino, and Asian Indian), 2.3% are American Indian, and 1.9% are Black or African-American. By contrast, the Chico/Glenn service area has a higher proportion of non-Hispanic Caucasians, while the Yuba/Sutter service area has larger shares of Hispanic/Latino and Asian (including Punjabi and other Afghan and Paki ethnic groups).

Race/Ethnicity[1]	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Caucasian, Non-Hispanic (incl. North African and West/ Central Asian)	46,160	64.4 %	36.5 %	60.1 %	70.8 %	47.5 %	128,628	76,517
Hispanic or Latino	14,024	19.6 %	39.1 %	18.2 %	19.7 %	31.1 %	35,682	50,158
Asian (South or East) or Asian Indian	4,919	6.9 %	14.8 %	5.6 %	3.8 %	13.3 %	6,973	21,373
Other/ Multiple (non-Hispanic)	4,167	5.8 %	3.7 %	3.1 %	3.7 %	4.8 %	6,703	7,755
American Indian, Alaska Native, Native Hawaiian, or Pacific Islander	1,671	2.3 %	1.2 %	1.0 %	1.5 %	2.6 %	2,701	4,219
Black or African American	1,386	1.9 %	5.7 %	12.6 %	1.2 %	1.7 %	2,212	2,735
Total	71,731	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	181,563	161,033
Total non-Caucasian	25,571	35.6 %	64.5 %	40.6 %	29.2 %	52.5 %	52,935	84,516

Source: U.S. Census Bureau, 2019 American Community Survey 5-Year Estimates, Table B03002.

[1]Hispanic/Latino is separated only from White and Other. It is duplicated in all other race categories.

Income disparity is experienced unequally by race and ethnicity. The per capita income for all residents within the service area ($24,083) is well below the state and national averages. However, the burden of income disparity is borne by certain ethnic groups in the service area such as Asians, Hispanics/Latinos, Blacks/African-Americans. and to a lesser extent American Indians. The lowest earning race/ethnicity within the service area are Asians, annually earning $13,859 per capita income. Next is Hispanics/Latinos at $17,913, followed by Blacks/African Americans earning $18,517 and American Indians at $23,373; all of which are below the service area average per capita income. Incomes in the Yuba/Sutter service area are marginally higher ($27,604 per capita) and in the Chico/Glenn service area higher still ($32,219 per capita), although both areas are short of both the state and national averages, and race/ethnic minorities have the same income inequality found in the Primary Service Area with Asians, Hispanics/Latinos, Blacks/African-Americans, and American Indians all having lower incomes per capita that their service area averages.

Income by Race/Ethnicity[1]	Primary SA	Calif.	U.S.A.	Chico/ Glenn SA	Yuba/ Sutter SA
Caucasian, Non-Hispanic	$ 27,500	$ 55,603	$ 41,758	$ 37,088	$ 34,156
American Indian, Alaska Native, Native Hawaiian, or Pacific Islander	$ 23,373	$ 27,238	$ 22,452	$ 28,528	$ 20,110
Black or African American	$ 18,517	$ 31,057	$ 24,454	$ 18,282	$ 33,556
Hispanic or Latino	$ 17,913	$ 21,952	$ 21,846	$ 19,799	$ 18,908
Asian (South or East) or Asian Indian	$ 13,859	$ 45,111	$ 42,331	$ 26,077	$ 25,118
Per capita income, all persons	$ 24,083	$ 38,576	$ 35,384	$ 32,219	$ 27,604

Source: U.S. Census Bureau, 2019 American Community Survey 5-Year Estimates, Tables B19301, B19301B through B19301D, B19301H, B19301I.

[1]Hispanic/Latino is separated only from White and Other. It is duplicated in all other race

According to data from the latest American Community Survey, nearly one in 10 Primary Service Area residents are foreign-born (9.7%). The majority of foreign-born are from Mexico with significant numbers also from Laos and Thailand (Hmong and Mien, primarily), and some from the Philippines and India (mostly Punjab and Gujarat). The secondary service areas, with larger populations, have larger numbers of residents from more countries. The Yuba/Sutter service area is the most diverse with nearly one in five (19.5%) residents being foreign born and larger populations from Mexico and India (mostly from Punjab), with significant populations from Laos and the Philippines.

Country of Birth	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
U.S. or U.S. Territories	64,784	90.3 %	73.4 %	86.5 %	92.9 %	80.5 %	168,634	129,645
Mexico	3,820	5.3 %	10.1 %	3.3 %	4.2 %	8.6 %	7,679	13,898
Laos	780	1.1 %	0.1 %	0.1 %	0.3 %	0.6 %	464	1,024
Thailand	397	0.6 %	0.2 %	0.1 %	0.2 %	0.3 %	282	413
Philippines	299	0.4 %	2.1 %	0.6 %	0.3 %	0.6 %	460	961
India	262	0.4 %	1.3 %	0.8 %	0.2 %	4.9 %	311	7,864
China (PRC)	*	*	1.7 %	0.7 %	0.4 %	0.2 %	769	249
Pakistan	*	*	0.1 %	0.1 %	0.1 %	0.3 %	161	438
Afghanistan	*	*	0.1 %	0.0 %	*	0.3 %	*	507
Korea	*	*	0.8 %	0.3 %	0.1 %	0.1 %	255	138
Vietnam	*	*	1.3 %	0.4 %	*	0.2 %	*	377
Japan	*	*	0.3 %	0.1 %	0.1 %	0.1 %	198	165
El Salvador	*	*	1.1 %	0.4 %	0.2 %	*	316	*
Russia	*	*	0.2 %	0.1 %	0.1 %	*	222	*
Nicaragua	*	*	0.2 %	0.1 %	*	0.1 %	*	218
Israel	*	*	0.1 %	0.0 %	*	0.1 %	*	171
Guatemala	*	*	0.7 %	0.3 %	0.1 %	*	166	*
Indonesia	*	*	0.1 %	0.0 %	0.1 %	*	152	*
Fiji	*	*	0.1 %	0.0 %	*	0.1 %	*	144
Cambodia	*	*	0.1 %	0.0 %	*	0.1 %	*	125
Brazil	*	*	0.1 %	0.1 %	*	0.1 %	*	108
All Other Nations	1,389	1.9 %	5.8 %	5.8 %	0.8 %	2.8 %	1,494	4,588
Total Population	71,731	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	181,563	161,033
Total Foreign-Born	6,947	9.7 %	26.6 %	13.5 %	7.1 %	19.5 %	12,929	31,388

Source: U.S. Census Bureau, 2020 American Community Survey 5-Year Estimates, Tables B05006 and B01003.

* calculated values of less than 100 are unreliable, and could be zero.

Language barriers are important to recognize as they can create obstacles that interfere with one's quality of life and health status. For example, residents may have trouble communicating their medical condition, which discourages them from seeking health information or treatment, as it has direct impact on their health and wellbeing. Obtaining a job is difficult for non-English speakers who are pushed into low-skill and low-wage occupations that require long working hours and no interaction with customers or clients. Integrating into the larger community is also a challenge as they may have difficulty connecting to, relating to, and understanding others who do not speak their primary language.

Almost one in five residents (18.1%) speak a language other than English at home in the Primary Service Area. Most of these residents speak Spanish (10.2% of the population ages 5+) and most of the rest speak Hmong (4.3%). There are residents present who speak other Asian languages (primarily Mien), other Indic languages (primarily Punjabi), Tagalog, Vietnamese, and Gujarati. As with national origin, the secondary service areas have more languages spoken at home, with the greatest diversity of languages found in the Yuba/Sutter service area where more than one-third (36.4%) of residents speak

a language other than English at home. Here, about one in five (20.1%) speak Spanish and another 6.7% speak other Indic languages (again, mostly Punjabi).

Primary Language Spoken at Home	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
English	54,757	81.6 %	56.1 %	79.0 %	84.7 %	67.2 %	145,007	96,584
Spanish	6,879	10.2 %	28.8 %	13.0 %	11.5 %	20.1 %	19,678	28,862
Hmong	2,901	4.3 %	0.2 %	0.1 %	0.7 %	1.5 %	1,123	2,126
Other Asian languages	512	0.8 %	0.5 %	0.4 %	0.5 %	1.9 %	782	*
Other Indic languages	330	0.5 %	0.6 %	0.3 %	0.2 %	6.7 %	307	9,688
Tagalog	301	0.4 %	2.2 %	0.6 %	0.4 %	0.7 %	600	1,028
Vietnamese	204	0.3 %	1.5 %	0.5 %	0.1 %	0.3 %	207	421
Gujarati	131	0.2 %	0.1 %	0.1 %	*	*	*	*
Chinese	*	*	3.1 %	1.0 %	0.5 %	0.7 %	782	998
Persian	*	*	0.5 %	0.1 %	0.1 %	0.3 %	223	396
Arabic	*	*	0.5 %	0.3 %	0.2 %	0.1 %	393	186
Russian	*	*	0.4 %	0.3 %	0.1 %	0.3 %	103	458
Portuguese	*	*	0.2 %	0.2 %	0.2 %	0.2 %	289	239
Laotian	*	*	0.1 %	0.1 %	0.2 %	0.1 %	311	136
Pacific Island languages	*	*	0.3 %	0.1 %	0.1 %	0.2 %	167	265
Hindi	*	*	0.5 %	0.2 %	0.1 %	0.2 %	146	267
Japanese	*	*	0.4 %	0.2 %	*	0.2 %	*	281
Urdu	*	*	0.1 %	0.1 %	*	0.2 %	*	273
Korean	*	*	1.0 %	0.4 %	*	0.1 %	*	141
African languages	*	*	0.2 %	0.3 %	*	0.1 %	*	119
All other languages	1,127	1.2 %	9.6 %	5.6 %	2.5 %	2.6 %	1,096	1,263
Total Population	67,142	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	171,214	143,731
Total Foreign-Born	12,385	18.0 %	50.9 %	24.1 %	17.2 %	36.4 %	26,207	47,147

Source: U.S. Census Bureau, 2015 American Community Survey 5-Year Estimates, Table B16001.
* calculated values of less than 100 are unreliable, and could be zero.

Some who do not speak English at home report speaking English “very well,” but many do not. For example, 3,308 of the 6,879 residents who speak Spanish at home in the Primary Service Area reported that they do not speak English “very well,” representing 4.9% of the population. There is also a significant population who speak Hmong (1,547) and a few who speak Tagalog and other Indic languages (Punjabi).

Persons who Don't Speak English "Very Well" (Percent of Persons Ages 5+)	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Spanish	3,308	4.9 %	12.3 %	5.5 %	3.8 %	8.6 %	6,471	12,290
Hmong	1,547	2.3 %	0.1 %	0.0 %	0.4 %	0.6 %	681	901
Tagalog	157	0.2 %	0.7 %	0.2 %	0.1 %	0.2 %	152	318
Other Indic languages	145	0.2 %	0.2 %	0.1 %	0.1 %	3.5 %	126	5,043
Chinese	*	*	1.8 %	0.6 %	0.3 %	0.3 %	526	415
Vietnamese	*	*	0.9 %	0.3 %	0.1 %	0.1 %	148	202
Persian	*	*	0.2 %	0.1 %	*	0.1 %	*	161
Russian	*	*	0.2 %	0.1 %	*	0.1 %	*	140
Portuguese	*	*	0.1 %	0.1 %	*	0.1 %	*	136
Japanese	*	*	0.2 %	0.1 %	*	0.1 %	*	127
Laotian	*	*	0.1 %	0.0 %	0.1 %	*	126	*
Urdu	*	*	0.0 %	0.0 %	*	0.1 %	*	110
Arabic	*	*	0.2 %	0.1 %	0.1 %	*	101	*
All other languages	783	1.2 %	1.9 %	1.3 %	0.2 %	0.4 %	454	575
Total ages 5+ who don't speak English "very well"	5,940	8.8 %	18.8 %	8.6 %	5.1 %	14.2 %	8,785	20,418

Source: U.S. Census Bureau, 2015 American Community Survey 5-Year Estimates, Table B16001.
* calculated values of less than 100 are unreliable, and could be zero.

Medical/Primary Care Health Outcomes

In total, the limited economic capacity of Oroville Hospital's Primary Service Area population, along with health behaviors, health conditions, and cultural, demographic, and environmental factors affecting health care demand and delivery, several adverse health outcomes are identified in this report. This section addresses adverse medical and primary care outcomes.

In this report, adverse medical outcomes are measured using age-adjusted deaths by underlying cause of mortality. Higher age-adjusted mortality rates indicate that mortality is occurring at younger ages than for a standard population, which in this case is the U.S. population in 2000. Therefore, age-adjusted mortality rates for causes of death indicate whether or not people are dying prematurely from those causes. Premature deaths can be linked to health behaviors, conditions, and other factors that are producing adverse health outcomes. These causes are grouped by the Centers for Disease Control and Prevention's 113 ICD-10 grouped causes of death, which are used to determine leading causes of death in the U.S.

The two leading causes of mortality, by far, are heart disease and cancer (malignant neoplasms), and both have age-adjusted mortality rates that far exceed the state and national averages, as well as the averages for Chico/Glenn and Yuba/Sutter. Heart disease has an age-adjusted mortality rate of 200.7 per 100,000 population compared to the state/national rates of 141.3/164.8, and for cancer the rate is 177.3 per 100,000 compared with the state/national averages of 134.6 and 149.4. These significantly higher rates indicate that these are major causes of premature death in the Primary Service Area.

Overall, 12 of the top 16 underlying causes of mortality in the Primary Service Area have mortality rates that are higher than average in both California and U.S. and thus all represent significant disparities in health outcomes. These include more common causes of mortality such as Alzheimer's disease; accidents; chronic lower respiratory diseases such as COPD, asthma, and pulmonary diseases; and cerebrovascular diseases such as stroke. Lesser common causes with higher premature mortality compared with the state and nation include diabetes, suicide, chronic liver disease such as cirrhosis, influenza/pneumonia, septicemia, and homicide. Most of these should not result in premature death with appropriate management through regular primary medical and behavioral health care.

The secondary service areas have their own unique mortality patterns. Compared with the Primary Service Area, the Chico/Glenn service area has higher rates of mortality from Alzheimer's, suicide, and Parkinson's disease. The Yuba/Sutter service area has higher rates from Parkinson's, hypertension, kidney disease such as nephritis and nephrosis, and septicemia.

Leading Causes of Mortality, Age-Adjusted Rates per 100,000 Population, Annual Average 2016-2020 (ICD-10)	Primary SA No.	Primary SA Pct.	Calif.	U.S.A.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Diseases of heart (I00-I09,I11,I13,I20-I51)	207	200.7	141.3	164.8	153.8	165.4	367	294
Malignant neoplasms (C00-C97)	198	177.3	134.6	149.4	136.9	147.6	351	289
Alzheimer's disease (G30)	55	53.2	37.6	30.8	55.1	38.6	136	69
Accidents (unintentional injuries) (V01-X59,Y85-Y86)	67	85.6	35.8	50.4	56.6	48.4	116	78
Chronic lower respiratory diseases (J40-J47)	61	55.3	30.5	39.1	41.0	46.9	101	87
Cerebrovascular diseases (I60-I69)	55	50.6	37.6	37.6	37.5	49.0	94	90
COVID-19 (U07.1)[1]	69	64.6	71.0	88.5	34.8	48.8	82	87
Diabetes mellitus (E10-E14)	29	29.2	22.4	22.1	17.3	21.7	39	39
Intentional self-harm (suicide) (X60-X84,Y87.0)	16	15.3	10.5	13.8	16.0	12.0	37	24
Chronic liver disease and cirrhosis (K70,K73-K74)	16	18.9	12.6	11.5	16.0	17.7	33	30
Influenza and pneumonia (J09-J18)	20	18.6	14.0	13.6	13.6	17.9	33	32
Parkinson's disease (G20-G21)	8	7.6	8.4	8.8	10.4	8.5	25	14
Essential hypertension and hypertensive renal disease (I10,I12,I15)	7	6.8	12.5	9.1	9.1	14.0	22	25
Nephritis, nephrotic syndrome and nephrosis (N00-N07,N17-N19,N25-N27)	10	8.7	9.0	12.9	7.3	15.2	18	27
Septicemia (A40-A41)	8	7.4	1.6	2.5	6.1	9.8	15	18
Assault (homicide) (X85-Y09,Y87.1)	6	7.4	5.1	6.4	2.1	6.2	5	10
All other causes	160	190.4	115.5	166.2	159.9	174.0	320	260
Annual Average Deaths, 2016-2020	928	939.2	630.7	747.6	743.4	796.6	1,723	1,393

Source: Gary Bess Associates, calculated from California Department of Public Health Master Death Files 2016-20 using the U.S. 2000 Standard Population. County, state, and national data are from Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 2016-2020 on CDC WONDER Online Database, released December, 2021.

[1]One-year mortality rates are calculated for COVID-19, only, for appropriate relative comparison with other

Behavioral Health Outcomes and Contributing Factors

Behavioral health is an umbrella term that encompasses mental health and substance use disorders (SUDs). SUD is characterized by substance use that results in clinically significant impairment or distress,[14] which is why marijuana, although now legal in California in many cases as is alcohol, is included in SUD analysis, while tobacco use is considered an adverse health behavior as previously described in this report. Medical coverages sometimes, but do not always, cover behavioral health care.

Mental Health Access: About one in nine Primary Service Area residents (11.1%) who indicated they needed treatment for self-reported mental/emotional or alcohol/drug issues did not receive treatment in the past year. It was more likely that those who received mental health care treatment were seen by a primary care provider rather than a mental health professional (11.5%), indicating the need for additional mental health specialists. Primary Service Area residents indicated they were also less likely to connect with a provider online, compared with average in California. Therefore, more work may need to be done to deliver mental health care through telehealth for the target population than for others.

Behavioral Health Access	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Did Not Receive Treatment for Self-Reported Mental/Emotional and/or Alcohol-Drug Issue(s) (ages, 18+, percent of those who indicated they needed help)	11,000	11.1 %	9.0 %	10.9 %	10.7 %	42,000	22,000
Primary care physician provided mental health care (ages, 18+, percent of adults receiving mental health care)	1,000	11.5 %	6.8 %	11.7 %	10.6 %	4,000	2,000
Has not connected with mental health professional online in the past year (ages 12+, percent who indicated they needed help)	10,000	15.4 %	5.9 %	17.1 %	4.8 %	44,000	8,000
Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 5-year average.							

Behavioral Health Impacts: The impacts of mental, emotional, and SUD issues are significant among Primary Service Area residents. Residents are more likely to have serious psychological distress in the past year (15.6%), and their distress is more likely to produce a moderate to severe impairment on their social and family lives (3.5%, each), doing routine household chores (3.4%), and work/employment impairment (3.4% of persons who work) which can limit economic mobility. Feelings of loneliness among Primary Service Area seniors is also an issue since about one-quarter of them (25.0%) met UCLA's three-item loneliness criteria. Also, residents were much more likely to have ever seriously thought about committing suicide (17.8%), compared with the state (12.1%). These impacts would not be as severe if lower income residents had better access to appropriate mental health care.

[14] https://web.archive.org/web/20150122085833/http://www.nami.org/content/contentgroups/policy/issues_spotlights/dsm5/substance_use_disorder_paper_4_13_2010.pdf

Behavioral Health Impacts (Ages 18+ Unless Otherwise Specified)	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Likely Had Serious Psychological Distress in the Past Year	9,000	15.6 %	10.8 %	15.5 %	13.3 %	37,000	20,000
Moderate to Severe Social Life Impairment Past year	2,000	3.5 %	1.9 %	3.4 %	2.9 %	8,000	4,000
Moderate to Severe Family Life Impairment Past year	2,000	3.5 %	1.9 %	3.5 %	2.6 %	8,000	4,000
Moderate to Severe Household Chore Impairment Past year	2,000	3.4 %	1.8 %	3.3 %	2.7 %	8,000	4,000
Moderate to Severe Work Impairment (Percent who Worked in the Past year)	1,000	3.4 %	1.8 %	3.2 %	2.6 %	4,000	2,000
Unable to Work More Than 30 Days in the Past Year Due to Serious Psychological Distress	1,000	6.1 %	3.7 %	6.2 %	4.6 %	2,000	1,000
Lonliness scale among seniors (ages 65+, UCLA 3-item lonliness scale, 2019)	4,000	25.0 %	23.1 %	24.7 %	22.1 %	12,000	6,000
Ever Seriously Thought About Committing Suicide	11,000	17.8 %	12.1 %	16.8 %	15.0 %	40,000	22,000

Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 5-year average, unless otherwise specified.

Substance Misuse Incidence: According to results from CHIS, alcohol use among adults and teens is higher in the Primary Service Area compared with the state average. Marijuana use is also higher, although this substance has recently been legalized for recreational use in California. Prescription pain killer use (opioids, primarily) is as high as in California (2.1% of adults misusing in the past year) and misuse rates for methamphetamines and prescription stimulants (such as Ritalin, Adderall, and a host of others) is much higher in the Primary Service Area compared with California. While drug misuse rates may seem low, misuse has a disproportionate toll on the community because it impacts family members and colleagues, and often results in higher use of the local justice system.

Substance Use (Ages 18+ Unless Otherwise Specified)	Primary SA No.	Primary SA Pct.	Calif.	Chico/ Glenn SA Pct.	Yuba/ Sutter SA Pct.	Chico/ Glenn SA No.	Yuba/ Sutter SA No.
Binge Drinking in the Past Year (2013-15)	23,000	38.6 %	32.9 %	38.2 %	32.0 %	91,000	47,000
Ever Had an Alcoholic Drink (Ages 12-17, 2016-20)	2,000	26.4 %	23.5 %	28.2 %	8.7 %	6,000	2,000
Ever Tried Marijuana or Hashish	43,000	65.5 %	46.6 %	64.2 %	46.0 %	166,000	76,000
Used Marijuana Within the Past Month	17,000	25.2 %	14.7 %	24.2 %	16.0 %	63,000	26,000
Ever Misused a Prescription Pain Killer	1,000	2.1 %	2.1 %	2.2 %	2.6 %	5,000	4,000
Used Heroin in Past year	<500	0.4 %	0.4 %	0.4 %	0.4 %	1,000	1,000
Ever used methamphetamines in past year	2,000	2.6 %	1.0 %	2.6 %	0.7 %	6,000	1,000
Prescription stimulant misused in past year	1,000	2.2 %	1.0 %	2.2 %	0.0 %	5,000	<500

Source: Gary Bess Associates, calculated from the 2020 California Health Interview Survey, 4-year average unless otherwise specified.

Identified Health Needs for 2022-2024

Based on input from community and provider surveys and an analysis of the data available, Oroville Hospital has identified six significant health needs that will be addressed in this CHNA action plan. They are 1) heart health, 2) mental health services 3) substance abuse, 4) access to affordable health care 5) obesity, and 6) poverty. These directives are consistent with the 2019 CHNA, which we partially addressed due to the advent of COVID-19 and an adjustment to the use of resources.

Diseases of the heart are the number one cause of death in the primary service area. Heart disease has an age-adjusted mortality rate of 200.7 per 100,000 population compared to the state/national rates of 141.3/164.8. Programs that provide education, training, and motivate efforts to reduce behaviors that increase the potential for heart disease such as smoking, obesity, poor diet, and lack of exercise are examples of opportunities available to reduce the impact of heart disease. The completion of the hospital expansion and the implementation of offering cardiothoracic surgery are expected once the project is complete.

The need for additional mental health services is evident from both community input and secondary statistical data. The indicated barriers to accessing mental health services when needed logically contributing to an incidence of mental health need higher than the average in California. In the secondary service areas, the Chico/Glenn area reflect similarly high needs, while the area of Yuba/Sutter less so. Barriers to care include access to mental health professionals in the community, along with a reluctance or inability to access online resources. Suicide rates higher than both the state and national average is a key indicator of the significance of the need for additional mental health resources.

Many mental health resources serve the dual treatment needs of mental health disease, and substance abuse, further straining the existing capacity of providers. Eight different metrics used to indicate substance abuse or the risk of future substance abuse were evaluated. All eight exceed the state average. In the secondary service areas, six of the eight metrics in the Glenn/Chico area exceed the state averages.

In the prior years' CHNAs, access to health care has been an important focus, and it has not abated. Respondents added specificity in their survey responses in 2022 listing access to affordable care as a priority. Most residents (93.8%) have some form of health care insurance. Poverty, housing issues, and unemployment all contribute to residents in the primary service area delaying or not obtaining needed health care due to cost or lack of insurance. Costs such as co-pays, deductibles, and prescription costs are in addition to any insurance premiums. 8.5% of residents in the primary service area did not obtain prescriptions when needed timely or at all in the primary service area. Additionally, where providers do not accept certain types of health insurance or insurance does not cover needed care, residents in poverty are often unable to pay out of pocket costs.

Obesity increases the risk of developing a preventable disease such as diabetes, cardiac and pulmonary disease, osteoarthritis, and stroke. Programs that educate, promote and support healthy living choices such as exercise, access to healthy food, weight management and other healthy habits have the potential to reduce multiple diseases. Prevention through the development of healthy habits that reduce the occurrence of obesity can significantly reduce the cost impact on patients as well as the demand on community and medical resources.

While poverty is not in itself a health need, challenges making healthy lifestyle choices and accessing health care as a result of circumstances surrounding poverty is. 62.5% of children ages 2-11 reported not eating the recommended servings of fruits and vegetables, while 19.2% of adults report fresh produce is not always available or affordable in their neighborhood. With limited financial resources, over 15% of individuals in the primary service area struggle to pay medical bills, with 5% going without basic necessities in order to pay for healthcare. Overcrowding, defined as households having more than one person per room, with a room defined as an enclosed area not including bathrooms, closets, and garages, but including kitchens, living rooms, dens, lofts, etc. Overcrowding can contribute to poor health because communicable diseases and illnesses are more easily spread in crowded conditions, and in general, it is difficult to keep common areas in the home clean/sanitary when there are many people living within the household. The data shows that overcrowding is a challenge in the primary service area, especially for renters. Overall, 5.9% of occupied housing units are overcrowded, although, for renter-occupied units, more than one in 10 (10.9%) are overcrowded. Generally, overcrowding in the service area is much worse than the national average of 3.3% of units, although not as bad as in California as a whole (8.2%). Overcrowding is about the same in the Yuba/Sutter service area as in the primary service area, although it is less in the Chico/Glenn service area.

2022-2024 CHNA Action Plan

Based on a review of prior CHNA reports, Oroville Hospital has addressed the health concerns with new and expanded services leading to improved health outcomes. Significant health challenges continue in the same domains as in prior years. In 2022, we have added specificity to the plan based on the new information uncovered during the needs assessment process.

Heart Health/Heart Disease

The heart is one of the most important organs of the body. It is the intent of Oroville Hospital to provide resources, education, programs and treatment to reduce the incidence of death from heart related diseases and conditions. Diseases of the heart are the number one cause of death in the primary service area. Heart disease has an age-adjusted mortality rate of 200.7 per 100,000 population compared to the state/national rates of 141.3/164.8. Programs that provide education, training, and motivate efforts to reduce behaviors that increase the potential for heart disease such as smoking, obesity, poor diet, and lack of exercise are examples of opportunities available to reduce the impact of heart disease. The completion of the hospital expansion and offering cardiothoracic surgery are expected once the project is complete.

In 2021, cardiologist Devinderjit Singh, MD joined the Oroville Hospital cardiology team, which includes Deepak Khanna, MD and Michael Johnston, MD. The team recognizes that lifestyle choices can have a large impact on patient health. They strive to provide each patient with comprehensive cardiovascular care, educating patients on the importance of diet and exercise to improve health and prevent heart disease. The hospital has programs that will be expanding and enhanced as they continue to focus their efforts to reduce the impact of heart disease such as their Cardiac Catheterization Lab and Cardiac Rehabilitation facilities. Oroville Hospital also has a remote patient monitoring program that gives free blood pressure monitors to patients who have one or more chronic conditions relating to hypertension. This allows patients access to devices and enhances the provider's visibility to their readings on an ongoing basis to improve patient care.

In 2018, Oroville Hospital expanded its Cardiology Program and added a Cardiac Catheterization Lab to address the large segment of the population that suffer from heart disease. The state-of-the art imaging within the Cath Lab, combined with the expertise of Oroville Hospital's Interventional Radiologist, patient's cardiovascular issues can now be diagnosed and treated before any irreversible damage is caused. Following a heart procedure or receiving a coronary diagnosis, patients can also take advantage of Oroville Hospital's cardiac rehabilitation services. The cardiac rehab program guides patients through the recovery process, enabling them to live their healthiest life with the greatest amount of independence.

According to the CDC, high blood pressure and high cholesterol are two common and major risk factors that lead to heart disease and stroke. In the United States 1 in 3 deaths are caused by chronic cardiovascular disease. To help alleviate these extreme risk factors, Oroville Hospital provides Chronic Care Management services to patients who are suffering from two or more chronic conditions (including heart disease and hypertension), and are established with an Oroville Hospital Primary Care Provider. The Chronic Care Management team is comprised of medical assistants who check in

with patients monthly to ensure that preventative measures, such as appropriate health screenings, are taking place in a timely matter. They also ensure that patients have all their required prescriptions filled, and that they are not experiencing any adverse side effects. Chronic Care Management medical assistants can also schedule or reschedule patients with any provider at Oroville Hospital, to take the burden off of the patient and higher the likelihood that patients receive the care they need to properly manage their chronic conditions.

Along with the clinical programs, Oroville hospital has preventative programs such as educational events that provide presentations, resources and guidance on topics that affect overall health as well as disease specific topics. Oroville Hospital continues to host weekly Farmers' Markets every year from May through October that are open to the community. The Farmers' Market gives many members of the community access to fresh and healthy foods. Having access to these types of foods are a key component to living a healthy lifestyle as well as help battle a variety of diseases including the leading killer, heart disease. Oroville Hospital will monitor the number of deaths in the medical service areas to evaluate the impact of this plan. Currently, in the primary service area, on average 8.5% (200.7 per 100,000 population) of the population have been diagnosed with some form of heart condition or disease. The hospital will also monitor the number of people ever diagnosed with a heart condition or heart disease with the hope that individuals will make lifestyle choices that reduce their risk of developing conditions that contribute to heart disease.

Mental Health

Mental health concerns in Butte County have always been present due to the lack of psychiatric services available. Oroville Hospital will continue to help provide the community with the mental health services needed. Oroville Hospital's Mental Well-Being Clinic is able to connect patients with essential mental health care services they need in a safe and welcoming environment. Under the supervision of Dr. Lynne Pappas, the hospital maintains a team of providers to assist patients in managing their mental health through medication management. For patients who need further assistance our providers will refer them out to receive the care they need. In addition, through Oroville Hospital's Mental Well-Being Clinic, Jacob Boyle, Psychologist can provide patients with therapy, psychological assessments and psychotherapy. Psychological assessments are offered for children and adults at the Mental Well-Being Clinic to assist in diagnosis and treatment planning. With these assessments, providers can provide practical feedback aimed at identifying strengths and weaknesses and help develop strategies to help improve a patient's quality of life. Individual psychotherapy consists of a wide range of goals such as building skills to overcome obstacles or manage difficult situations, helping facilitate behavior change, increase happiness, build self-esteem, and develop greater self-awareness.

Oroville Hospital has increasingly been referring patients in need to the Butte 2-1-1 service line that connects individuals with a plethora of resources that are available throughout Butte County. The resources available address a wide range of needs including, but not limited to, mental health issues, crisis management, domestic violence, homelessness and substance abuse.

In certain circumstances, patients require a higher level of psychiatric care that requires an inpatient setting. To streamline the transfer of care for the patient, Oroville Hospital has developed a transportation department that has drivers who are CIT (Crisis Intervention Team) Certified and are

able to transport patients from Oroville Hospital to an Inpatient Psychiatric Care Hospital. By having drivers that are available 24/7, Oroville Hospital is able to provide patients that are needing to be transferred to an inpatient facility with rides at any time so they will not have to wait long periods of time in the Emergency Department. This also frees up a highly demanded bed in the Emergency Department for other patients in need.

Oroville Hospital's Stroke and Cancer Support Groups brings together survivors, caregivers, family and friends. The support groups help individuals with similar situations talk about their personal experiences to help heal and head toward a healthier and more positive life. At the meetings participants are given a safe place to discuss how cancer and stroke has affected their life in a group setting to encourage healing.

About one in nine Primary Service Area residents (11.1%) who indicated they needed treatment for self-reported mental/emotional or alcohol/drug issues did not receive treatment in the past year. It was more likely that those who received mental health care treatment were seen by a primary care provider rather than a mental health professional (11.5%), indicating the need for additional mental health specialists. Primary Service Area residents indicated they were also less likely to connect with a provider online, compared with average in California. Oroville hospital will review, revise and implement guidance and training surrounding resources available for mental health care encouraging primary care physicians to collaborate with the Mental Well-Being Clinic with a goal of transferring mental health case load to Mental Health professionals as well as providing ease of access to services for those that did not seek recommended services.

Substance Abuse

According to results from CHIS, alcohol use among adults and teens is higher in the Primary Service Area compared with the state average. Marijuana use his also higher, although this substance has recently been legalized for recreational use in California. Prescription pain killer use (opioids, primarily) is as high as in California (2.1% of adults misusing in the past year) and misuse rates for methamphetamines and prescription stimulants (such as Ritalin, Adderall, and a host of others) is much higher in the Primary Service Area compared with California. While drug misuse rates may seem low, misuse has a disproportionate toll on the community because it impacts family members and colleagues, and often results in higher use of the local justice system.

To minimize the risk factors of patients developing a dependency on pain killers, specifically opioids, Oroville Hospital has developed multiple pain management policies. To begin, when a patient presents to the Emergency Department with a chief complaint of chronic pain, the hospital does not prescribe controlled substances. Instead, the patient is stabilized using alternative and effective measures, then directed to one of Oroville Hospital's two Comprehensive Pain and Spine Centers, or to a primary care provider. This ensures that the patient's chronic condition is closely monitored, and receives an appropriate treatment plan that is tailored to the patient's specific circumstances. If the patient does indeed require a prescription for a controlled substance, it is exponentially safer for them to receive continuous treatment through the Comprehensive Pain and Spine Center and/or through their established primary care provider. In the event that a patient does require a controlled substance, providers across all departments are required to look up the patient through the CURES (Controlled

Substance Utilization Review and Evaluation System) data base. This allows providers to see if patients have received a controlled substance prescription from another facility, and reduces a patient's ability to abuse prescription drugs.

Through the use of Oroville Hospital's two Comprehensive Pain and Spine Centers that provide services and treatment for all types of pain stemming from a variety of different causes and by incorporating many treatment methods such as physical and occupational therapy, counseling, and targeted therapeutic injections, patients are able to achieve whole body wellness without the use of high-dose controlled substances. The clinic has two programs, one addresses addictive disorders and the other assists patients with chronic pain management. In collaboration with the Mental Well-Being Clinic team, patients are supported through the recovery process along with other treatments needed both medically and behaviorally.

Access to Affordable Health Care

Access to health care has long been a priority need identified in the Oroville Hospital Service Areas. The hospital has implemented many programs to reduce barriers to accessing health care. Programs implemented include transportation, translation, additional providers, tele-health, and specialized programs provided locally. In the prior years' CHNAs, access to health care has been an important focus, and it has not abated. Respondents added specificity in their survey responses in 2022 listing access to affordable care as a priority. The majority of residents (93.8%) have some form of health care insurance. Poverty, housing issues, and unemployment all contribute to residents in the primary service area delaying or not obtaining needed health care due to cost or lack of insurance. Costs such as co-pays, deductibles, and prescription costs are in addition to any insurance premiums. 8.5% of residents in the primary service area did not obtain prescriptions when needed timely or at all in the primary service area. Additionally, where providers do not accept certain types of health insurance or insurance does not cover needed care, patients both in poverty and just above are often unable to pay out of pocket costs.

When looking at the costs of healthcare, there are additional costs to consider include, insurance premiums, copays, deductibles and costs of over-the-counter products often not covered by insurance. There are additional non-medical costs attributed to accessing health care including work time lost, transportation costs and child/dependent care costs incurred. The current popular solution is tele-health and virtual visits. Those technological resources also have a cost. The patient is now expected to provide the technological equipment sufficient for the provider to see and hear the patient, and internet or cellular connectivity all at a bandwidth able to support video conferencing.

In 2020, Oroville hospital greatly expanded its telemedicine services. This allowed patients that may not have transportation or limited availability to leave work to go to an appointment and still have access to health care services. The service is available for primary care, specialty care and even urgent care.

Oroville Hospital is anticipating to open their 5-story tower in spring 2023. This will increase access by increasing capacity from 153 bed facility to a 211 bed facility. With the increase in beds, the emergency room will be able to increase its throughput and minimize wait times. Along with the expansion, Oroville Hospital will also be introducing new services such as, neuro surgery,

cardiothoracic surgery, as well as obtain a trauma 2 designation to reduce a patient's need to travel to receive appropriate care. This will allow patients to remain closer to home and be closer to loved ones during their time of need.

Obesity/Diabetes

In an effort to help alleviate and prevent overweight and obesity rates, Oroville Hospital offers the "Fitness for Kids" programs that introduces and builds on basic health concepts, including nutrition and physical activity information. Weekly classes are held in the fall and spring and cover topics including: reading food labels, getting daily physical activity, and setting and monitoring appropriate health goals.

The diet and nutrition habits developed as a child, continue into adulthood. Eating right and learning about good nutrition are important, whether you have a specific medical condition or just want to adopt a healthier lifestyle. At Oroville Hospital, we have a highly dedicated team of Registered Dietitians that work with patients and their primary care providers to develop an individualized meal plan that fosters ongoing support for attaining the best possible health outcomes. Oroville Hospital dietitians offer consultations and education for patients needing assistance with menu planning, food preparation, healthy activities, and exercises. Dieticians partner with care providers to evaluate and educate patients regarding any underlying conditions that may be contributing to obesity. More frequently, obesity is a primary indicator and contributor to the risk of developing serious disease.

Diabetes is a disease that appears to have a direct correlation to obesity. The disease can often be managed with proper diet and exercise, reducing the need for expensive medications and treatments. Just as with heart disease, Oroville hospital relies on its Chronic Care Management team to support patients with diabetes. The Chronic Care Management team is comprised of medical assistants who check in with patients monthly to ensure that preventative measures, such as appropriate health screenings, are taking place in a timely matter. They also ensure that patients have all of their required prescriptions filled, and that they are not experiencing any adverse side effects. Chronic Care Management medical assistants can also schedule or reschedule patients with any provider at Oroville Hospital, to take the burden off of the patient and higher the likelihood that patients receive the care they need to properly manage their chronic conditions and reduce the incidence of diabetic complications and death.

Poverty

The hospital can address some of the challenges of poverty throughout the service areas. The opening of the Plumas House facility by Oroville Hospital established a new care facility, to assist patients, who may be displaced, homeless, or living in overcrowding housing, after their stay at the hospital. Plumas House is a six-bed care facility used to provide patients who are displaced with a safe, supportive, and healing environment to rest in. Plumas House provides patients with 24/7 direct care staff, daily meal service, and transportation to medical and dental appointments via Oroville Hospital's Golden Valley Transportation service. Plumas House provided services to 87 individuals in 2021. Oroville Hospital will continue to evaluate the needs of displaced persons and work to develop resources to support recovery and care continuity, both after hospitalization and after out-patient and clinical care.

Hosting the farmers market and providing the technology to accept EBT transactions provides the community with access to fresh produce that is affordable. As more resources become accessible through technology, Oroville hospital will consider and evaluate options for those that do not have or cannot afford the technology to take advantage of on-line services, such as setting/confirming appointments, tele-medicine, accessing the health library and website resources or even applying for a job at the hospital.

Oroville Hospital has remained committed to enhancing the equitable well-being and quality of life of the exceptional community. Throughout the years, an abundance of thought and intention has gone into cultivating business practices that facilitate an environment where staff, providers, patients and community members feel represented, understood and appreciated. The business practices of the hospital reflect the commitment of the organization to supporting minority and underserved businesses, recruiting staff that are rich in cultural diversity and providing equitable wages and benefits, and engaging with all members of the community with respect and dignity. The hospital will continue to develop programs and resources to facilitate healing and healthy future for those individuals living in poverty in the service areas. Monitoring the number of individuals served at the Plumas House programs will demonstrate the hospitals commitment to support patients in need of extra assistance.

Measurement and Baseline Metrics

In order to evaluate the impact of the actions taken as a result of this needs assessment, Oroville Hospital used the metrics identified below as a baseline to develop its action plan and as a tool to monitor future impact.

Identified Need	Metric used to evaluate need	Primary Service Area 2022 CHNA	Chico/Glenn Secondary Service Area	Yuba/Sutter Secondary Service Area
Heart Health	*# of deaths from heart disease*	207	367	294
	% ever diagnosed with heart disease	8.5%	8.5%	8.5%
Mental Health Services	*% who did not obtain treatment*	11.1%	10.9%	10.7%
	% treated by primary care physician	11.5%	11.7%	10.6%
Substance Abuse	*% who used/abused prescription pain killer*	2.1%	2.2%	2.6%
Affordable Health Care	*# who delayed or did not obtain care*	14.9%	15.1%	11.3%
	# who delayed or did not obtain needed prescriptions	11.9%	11.9%	12.5%
Obesity	*# of deaths due to diabetes*	29	39	39
	Total % of diabetes Issues	20.2%	20.6%	27.1%
Poverty*	Total # served at Plumas House	87	n/a	n/a

Source: All metrics reported and source referenced in the secondary data section of this 2022 CHNA report.

*Number served at Plumas House taken from 2021 Oroville Hospital Community Benefit Report

Appendices

APPENDIX A:

Oroville Hospital Community Health Survey 2022

Thank you for choosing to participate in the 2022 Oroville Hospital Community Health Survey. By completing this survey, we will get a better understanding of the community we serve, and what health concerns are most important to residents like yourself. With this information we will construct and implement an action plan that addresses these concerns, and make Oroville and its surrounding communities a healthier and happier place to call home.

This is an **anonymous** survey and we want to assure you that your responses will be kept **strictly confidential**. If you do not wish to answer a question, or if a question does not apply to you, you may leave your answer blank. The survey will take about 5-10 minutes to complete.

SECTION 1: About You and Your Family

Check the boxes that best apply to you, and/or your child(ren) under the age of 18.

1. About how tall are you (without shoes)? _____
   About how much do you weigh (without shoes)? _____

2. How would you classify your gender identity?
   - ☐ Male ☐ Female
   - ☐ If your identity is not listed above, please self-identify: _____.
   - ☐ Choose not to disclose.

3. What is your home zip code? _____

4. Your age:
   - ☐ 25 or younger ☐ 26-39 ☐ 40-54
   - ☐ 55-64 ☐ 65 or older

5. What is your race?
   - ☐ White ☐ Black/African American ☐ American Indian/ Alaska Native
   - ☐ Hispanic/Latino ☐ Hmong ☐ Asian (other than Hmong)
   - ☐ Multiple ☐ Native Hawaiian/Other Pacific Islander
   - ☐ Other: _____

6. What is your marital status?
   - ☐ Single/Never married ☐ Married ☐ Divorced
   - ☐ Unmarried couple ☐ Separated ☐ Widowed
   - ☐ No answer

7. Are you currently employed?
   - ☐ Not employed ☐ Self-employed ☐ Employed part-time
   - ☐ Employed full-time ☐ Disabled ☐ Retired

8. Do you have a child or children under the age of 18?
   - ☐ Yes ☐ No

If yes, what type of school is your child(ren) enrolled in?

☐ Public ☐ Faith-based ☐ Charter
☐ Homeschool ☐ Other: _____

9. What is your highest level of education?

☐ Elementary school ☐ Middle school ☐ High school
☐ Some college ☐ Associate degree ☐ Bachelor's degree
☐ Graduate school ☐ Technical/Trade school ☐ Union apprenticeship
☐ Other: _____

10. What is your annual household income before taxes?

☐ Less than $30,000 ☐ $30,000-$60,000 ☐ $60,001-$90,000
☐ $90,001-$120,000 ☐ Over $120,000 ☐ Not sure
☐ No answer

11. How would you describe the overall health of you and/or your child(ren)?

You:

☐ Very good ☐ Good ☐ Fair
☐ Poor ☐ Not sure

Child(ren):

☐ Very good ☐ Good ☐ Fair
☐ Poor ☐ Not sure

12. On average, how many days per week do you get at least 30 minutes of exercise or other physical activity?

Examples: walking, running, weight-lifting, team sports or gardening

You:

☐ 5-7 days ☐ 3-4 days ☐ 1-2 days
☐ Only occasionally ☐ Not at all

Child(ren):

☐ 5-7 days ☐ 3-4 days ☐ 1-2 days
☐ Only occasionally ☐ Not at all

13. What obstacles prevent you from getting regular exercise?

☐ Not enough time in the day
☐ I don't know how to properly exercise
☐ I don't know where to go for exercise
☐ I am not healthy enough to exercise
☐ It's hard to stay motivated
☐ Not sure
☐ Other: _____

14. Do you use, or have you used, any of the following substance?

Check each box that applies:

	Every day	Most days	Occasionally	Past use	Never
Alcohol					
Cigarettes					
Electronic cigarettes					

Cigars, chew, or snuff					
Cocaine					
Crystal Methamphetamine (Meth)					
Heroin					
Marijuana					
Unprescribed prescriptions					

15. If you are a current or former smoker, are you aware of Oroville Hospital's smoking cessation program?

☐ Yes ☐ No ☐ N/A

Are you interested in joining the program?

☐ Yes ☐ No

☐ Maybe ☐ Currently or formerly enrolled

SECTION 2: About Your Health and Health Care

16. Do you have a Primary Care Physician (PCP)?

You:

☐ Yes ☐ No ☐ Yes, but I don't see him/her regularly

Child(ren):

☐ Yes ☐ No ☐ Yes, but I don't see him/her regularly

17. If you answered "yes" please list your doctor's name:

_____

18. If you do not see a primary health provider regularly, please tell us why.

Check all that apply.

☐ I don't know how to find a good doctor ☐ I am uncomfortable with doctors

☐ My doctor has inconvenient hours ☐ Language, racial, or cultural barriers

☐ It costs too much money ☐ Lack of transportation

☐ Other: _____

19. What other kinds of health care professionals do you visit regularly?

Check all that apply.

You:

☐ Medical specialist ☐ Dentist ☐ Eye doctor

☐ Mental Health Professional ☐ Home care nurse ☐ Spiritual healer

☐ Alternative healer (ex: Chiropractor) ☐ Other: _____

Child(ren):

☐ Medical specialist ☐ Dentist ☐ Eye doctor

☐ Mental Health Professional ☐ Home care nurse ☐ Spiritual healer

☐ Alternative healer (ex: Chiropractor) ☐ Other: _____

20. Where do you and your family members receive routine health care services?

You:

☐ Doctor's office ☐ Urgent/prompt care ☐ Emergency room
☐ Free/low-cost clinic ☐ Homeless shelter ☐ School-based clinic
☐ Tribal Health Center ☐ No routine health care

Child(ren):

☐ Doctor's office ☐ Urgent/prompt care ☐ Emergency room
☐ Free/low-cost clinic ☐ Homeless shelter ☐ School-based clinic
☐ Tribal Health Center ☐ No routine health care

21. Did you have health insurance during all, part or none of the past year?

You:

☐ All year ☐ Part of the year ☐ No insurance all year

Child(ren):

☐ All year ☐ Part of the year ☐ No insurance all year

22. Currently, what is your primary type of health care coverage?

You:

☐ Employer-sponsored plan ☐ Private insurance ☐ Medicare
☐ Medi-Cal ☐ No health insurance ☐ Not sure

Child(ren):

☐ Employer-sponsored plan ☐ Private insurance ☐ Medicare
☐ Medi-Cal ☐ No health insurance ☐ Not sure

23. *Which hospital do you normally go to for care?*

☐ *Oroville Hospital* ☐ *Enloe Medical Center* ☐ *Orchard Hospital*
☐ *Adventist Health Rideout* ☐ *Other:* _____

FOR WOMEN, AGE 21 AND OLDER:

24. How long has it been since your last pap smear (a screening exam for cervical cancer)?

☐ Within 1 year ☐ Within 2 years ☐ Within 3 years
☐ Within 4 years ☐ 5 or more years ☐ Never
☐ Not sure ☐ N/A

FOR WOMEN, AGE 40 AND OLDER:

25. How long has it been since your last mammogram (a screening exam for breast cancer)?

☐ Within 1 year ☐ Within 2 years ☐ Within 3 years
☐ Within 4 years ☐ 5 or more years ☐ Never
☐ Not sure ☐ N/A

FOR MEN, AGE 50 AND OLDER:

26. How long has it been since your last rectal exam (a screening used to examine the prostate)?

☐ Within 1 year ☐ Within 2 years ☐ Within 3 years
☐ Within 4 years ☐ 5 or more years ☐ Never
☐ Not sure ☐ N/A

27. How long has it been since you had a prostate cancer screening blood test?

☐ Within 1 year ☐ Within 2 years ☐ Within 3 years
☐ Within 4 years ☐ 5 or more years ☐ Never
☐ Not sure ☐ N/A

FOR MEN AND WOMEN, AGE 50 AND OLDER:

28. How long has it been since your last colonoscopy (a screening exam for colon cancer)?

☐ Within 1 year ☐ Within 2 years ☐ Within 5 years
☐ Within 10 years ☐ Over 10 years ☐ Never
☐ Not sure ☐ N/A

How long has it been since your last sigmoidoscopy (a screening exam for colorectal cancer)?

☐ Within 1 year ☐ Within 2 years ☐ Within 5 years
☐ Within 10 years ☐ Over 10 years ☐ Never
☐ Not sure ☐ N/A

FOR EVERYONE:

29. Have you ever experienced suicidal or homicidal ideations?

☐ Yes ☐ No ☐ Not sure

30. Have you ever been told by a doctor or health care professional that you, and/or your child(ren), have any of the following conditions, diseases or challenges? *Check all that apply.*

You:

☐ Asthma ☐ Cancer ☐ Diabetes
☐ Heart Disease ☐ Substance Abuse ☐ Overweight/Obesity
☐ Eating Disorder ☐ Genetic Disorder ☐ Birth Defect
☐ Mental/Emotional Condition (including Depression)
☐ Developmental & Learning Concerns (including Autism)
☐ Other:_____ ☐ N/A

Child(ren):

☐ Asthma ☐ Cancer ☐ Diabetes
☐ Heart Disease ☐ Substance Abuse ☐ Overweight/Obesity
☐ Eating Disorder ☐ Genetic Disorder ☐ Birth Defect
☐ Mental/Emotional Condition (including Depression)
☐ Developmental & Learning Concerns (including Autism)
☐ Other:_____ ☐ N/A

31. Within the past year, what types of mental health services did you and/or your child(ren) use?

Check all that apply.

You:

☐ Counseling/Therapy ☐ Hospitalization ☐ Crisis care/Emergency mental health services
☐ Residential treatment ☐Psychiatric Medication Management
☐ Behavioral/Mental Health Clinic
☐ Other: _____
☐ N/A

Child(ren):

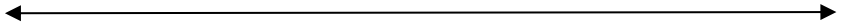
☐ Counseling/Therapy ☐ Hospitalization ☐ Crisis care/Emergency mental health services
☐ Residential treatment ☐Psychiatric Medication Management
☐ Behavioral/Mental Health Clinic
☐ Other: _____
☐ N/A

If you were in need of services, but were unable to access them, please explain why:

_____

32. Do you feel that you have adequate access to quality health care?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never



If you feel you do not have adequate access, what is the biggest problem?

Please write in your 1st, 2nd, and 3rd choice.

__ Transportation __ Cost __ Long wait times

__ Cultural/language barriers __ Lack of specialty doctors __ Inadequate or no insurance

__ Doctors not accepting new patients

__ Other: _____

33. Where do you receive information about local health services?

Check all that apply:

☐ Mail and flyers ☐ Online ☐ Social media

☐ TV advertisements ☐ Radio advertisements

☐ Print advertisements (ex: newspaper, Upgraded Living)

34. How would you prefer to receive your health information?

Check all that apply.

☐ Traditional mail ☐ Email ☐ Phone calls

☐ Text message

SECTION 3: Social and Community Context

35. Has anyone made you feel afraid for your personal safety or physically hurt you?

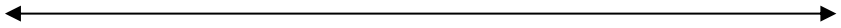
☐ Yes ☐ No ☐ Not sure

If yes, what relationship is this person (or people) to you?

_____

36. How often do you experience unwanted stress?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never



37. How satisfied are you with Oroville's school system?

☐ Very satisfied ☐ Satisfied ☐ Neutral

☐ Dissatisfied ☐ Very dissatisfied

If you are not satisfied, what do you think could be improved?

Please write in your 1st, 2nd, and 3rd choice.

__ Curriculum __ Breakfast/lunch programs __ Extra-curricular activities

__ After school programs __ Educators __ Safety

__ Infrastructure (ex: classrooms, playgrounds)

__ Other: _____

38. Do you feel that there are enough extra-curricular activities available to children in Oroville and the surrounding communities?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

What improvements do you think would be beneficial?

_____

PLEASE WRITE IN YOUR 1ST, 2ND, AND 3RD CHOICE FOR EACH OF THE FOLLOWING:

39. *Most important factors for a "Healthy Community"*

__ *Low crime/safe neighborhoods*
__ *Access to affordable health care*
__ *Affordable housing*
__ *Healthy behaviors and lifestyles*
__ *Access to affordable fresh/natural foods*
__ *Access to substance abuse programs/support*
__ *Good schools*
__ *Lots of parks & recreation opportunities*
__ *Good jobs/Healthy economy*
__ *Clean environment*
__ *Access to mental health services*
__ *Other:* _____

Greatest needs affecting "Children's Health"

__ *Access to immunizations*
__ *Access to mental health services*
__ *Affordable healthy lifestyle programs*
__ *Affordable services for special needs*
__ *Better child/day care options*
__ *Lack of physical activity*
__ *Access to health care services*
__ *Access to affordable fresh/natural foods*
__ *Affordable health insurance*
__ *Better school-lunch programs*
__ *Access to free health screenings*
__ *Safe places to play*
__ *Other:* _____

Most important "Health Problems" facing our community

__ *Cancer*
__ *Stroke*
__ *Respiratory/Lung disease*
__ *Suicide*
__ *Shortage of Primary Care Doctors*
__ *Diabetes*
__ *Overweight/Obesity*
__ *Dental hygiene*
__ *Teen pregnancy*
__ *Heart disease/High blood pressure*
__ *Mental Health Issues*
__ *Sexually transmitted infections (STIs)*
__ *Infectious diseases (ex: Hepatitis, TB)*
__ *Other:* _____

Most challenging "Risky Behaviors" facing our community

__ *Alcohol abuse*
__ *Child abuse/neglect*
__ *Poor eating habits*
__ *Not wearing a seatbelt*
__ *Drug abuse*
__ *Lack of exercise*
__ *Dropping out of school*
__ *Other:* _____
__ *Driving while under the influence*
__ *Tobacco use/secondhand smoke*
__ *Not wearing a helmet*

SECTION 4: Neighborhood and Built Environment

40. *Do you feel that you have adequate access to affordable and healthy food?*

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

If you feel you do not have adequate access, why not?
Please write in your 1st, 2nd, and 3rd choice.

__ *Too costly*
__ *Not enough time to shop*
__ *No transportation*
__ *Don't know what to buy*
__ *Not available in grocery stores*

__ *Other:* _____

41. *Are you satisfied with your current housing situation?*

☐ *Yes* ☐ *No*

If no, why not?
Please write in your 1st, 2nd, and 3rd choice.

__ *Too small* __ *Too expensive* __ *Too many people living in the same home*
__ *Problems with neighbors* __ *Too far from town/services* __ *Too run down, unsafe, or unhealthy*
__ *Other:* _____ _____

42. *Did you delay accessing health care due to the COVID-19 pandemic?*

☐ *Yes* ☐ *No* ☐ *Temporarily*

If so, what type of health care did you delay?
Check all that apply.

__ *Routine checkup* __ *Preventative care* __ *Urgent care*
__ *Emergency care* __ *Other:* _____

Do you feel that your overall health was negatively impacted by this delay in care?

☐ *Yes* ☐ *No*

43. *Did you experience any barriers to getting the COVID-19 vaccine when you became eligible?*
Check all that apply.

__ *Transportation* __ *Lack of internet access* __ *Long wait times*
__ *Appointment availability* __ *Cultural/language barrier* __ *No time off work/school*
__ Other: _____

44. Do you feel safe in the environment that you live in?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

45. What changes would you like to see made in order to improve the neighborhood you live in?

☐ Better roads ☐ Better lighting ☐ Better parks/playgrounds
☐ More sidewalks ☐ Increased security
☐ Other: _____

46. Where did you learn about this survey?

☐ At the hospital ☐ At my church ☐ At a health fair
☐ From a friend ☐ Online ☐ From my doctor
☐ At a community meeting ☐ At a retail store ☐ At work
☐ Other: _____

IS THERE ANYTHING WE'VE OVERLOOKED?

Feel free to write in additional information you think we should know about the health of our community.

Thank you for your time!

Your anonymous response will be used by Oroville Hospital to better serve the health needs of our community's residents.

APPENDIX B:

Oroville Hospital Employee Community Health Survey 2022

Thank you for choosing to participate in the Oroville Hospital Employee Community Health Survey. By completing this survey, we will get a better understanding of the community we serve, and what health concerns are most important to those who work within the health care system. With this information we will construct and implement an action plan that addresses these concerns, and make Oroville and it's surrounding communities a healthier and happier place to work and live.

This is an **anonymous** survey and we want to assure you that your responses will be kept **strictly confidential**. If you do not wish to answer a question, or if a question does not apply to you, you may leave your answer blank. The survey will take about 5 minutes to complete.

SECTION 1: Health Rankings

PLEASE WRITE IN YOUR 1ST, 2ND, AND 3RD CHOICE FOR EACH OF THE FOLLOWING:

1. Most important factors for a "Healthy Community"

__ Low crime/safe neighborhoods
__ Access to affordable health care
__ Affordable housing
__ Healthy behaviors and lifestyles
__ Access to affordable fresh/natural foods
__ Access to substance abuse programs/support
__ Good schools
__ Lots of parks & recreation opportunities
__ Good jobs/Healthy economy
__ Clean environment
__ Access to mental health services
__ Other: _____

Greatest needs affecting "Children's Health"

__ Access to immunizations
__ Access to mental health services
__ Affordable healthy lifestyle programs
__ Affordable services for special needs
__ Better child/day care options
__ Lack of physical activity
__ Access to health care services
__ Access to affordable fresh/natural foods
__ Affordable health insurance
__ Better school-lunch programs
__ Access to free health screenings
__ Safe places to play
__ Other: _____

Most important "Health Problems" facing our community

__ Cancer
__ Stroke
__ Respiratory/Lung disease
__ Suicide
__ Shortage of Primary Care Doctors
__ Diabetes
__ Overweight/Obesity
__ Dental hygiene
__ Teen pregnancy
__ Heart disease/High blood pressure
__ Mental Health Issues
__ Sexually transmitted infections (STIs)
__ Infectious diseases (ex: Hepatitis, TB)
__ Other: _____

Most challenging "Risky Behaviors" facing our community

__ Alcohol abuse __ Drug abuse __ Driving while under the influence
__ Child abuse/neglect __ Lack of exercise __ Tobacco use/secondhand smoke
__ Poor eating habits __ Dropping out of school __ Not wearing a helmet
__ Not wearing a seatbelt
__ Other: _____

SECTION 2: Patient Health and Wellness

2. Do you feel that patients have adequate access to quality health care?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

If you feel they do not have adequate access, what is the biggest problem?
Please write in your 1st, 2nd, and 3rd choice.

__ Transportation __ Cost __ Long wait times
__ Cultural/language barriers __ Doctor shortage __ Inadequate or no insurance
__ Other: _____

3. Do you feel that patients have adequate access to affordable and healthy food?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

If you feel they do not have adequate access, what is the biggest problem?
Please write in your 1st, 2nd, and 3rd choice.

__ Too costly __ Lack of transportation __ Not available in local stores
__ Patients don't have enough time to shop __ Patients don't know what to buy
__ Other: _____

4. What health care services would you like to see expanded to better meet the needs of our community?
Please write in your 1st, 2nd, and 3rd choice.

__ Ambulatory care __ Behavioral/Mental health __ Cancer care
__ Cardiac care __ Childbirth services __ Emergency services
__ Home health care __ Nutritional therapy __ Pain management
__ Palliative care __ Pediatric services __ Primary care
__ Respiratory care __ Smoking cessation __ Stroke program
__ Telemedicine __ Women's health __ Other: _____

5. Do you feel that patients delayed accessing health care due to the COVID-19 pandemic?

☐ Yes ☐ No ☐ Temporarily

If so, what type of health care did you feel was delayed?
Check all that apply.

__ Routine checkup __ Preventative care __ Urgent care
__ Emergency care __ Other: _____

Do you feel that patient's overall health was negatively impacted by this delay in care?

☐ Yes ☐ No

6. Did you feel that there were any barriers to getting the COVID-19 vaccine when patients became eligible?
Check all that apply.

__ Transportation __ Lack of internet access __ Long wait times
__ Appointment availability __ Cultural/language barrier __ No time off work/school
__ Other: _____

SECTION 3: About You, Your Family and Our Community

7. Your age:

☐ 25 or less ☐ 26-39 ☐ 40-54
☐ 55-64 ☐ 65 or older

8. What is your home zip code? _____

9. Do you have a child or children under the age of 18?

☐ Yes ☐ No

If yes, what type of school is your child(ren) enrolled in?

☐ Public ☐ Faith-based ☐ Charter
☐ Homeschool ☐ Other: _____

10. What is your impression of Oroville's school systems?

☐ Very good ☐ Good ☐ Acceptable ☐ Poor ☐ Very Poor

What do you think could be improved?
Please write in your 1st, 2nd, and 3rd choice.

__ Curriculum __ Breakfast/lunch programs __ Extra-curricular activities
__ After school programs __ Educators __ Safety
__ Infrastructure (ex: classrooms, playgrounds)
__ Other: _____

11. Do you feel that there are enough extra-curricular activities available to children in Oroville and the surrounding communities?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

12. Are you satisfied with Oroville's current housing market?

☐ Yes ☐ No ☐ N/A

If no, why not? *Please write in your 1st, 2nd, and 3rd choice.*

__ Too small __ Too expensive __ Too many people living in the same home
__ Problems with neighbors __ Too far from town/services __ Too run down, unsafe, or unhealthy
__ Other: _____

13. What changes would you like to see made in order to improve the neighborhood you live in?

☐ Better roads ☐ Better lighting ☐ Better parks/playgrounds
☐ More sidewalks ☐ Increased security
☐ Other: _____

14. Do you and/or your family utilize services provided by Oroville Hospital?
☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

15. How likely are you to recommend Oroville Hospital to friends and family?
☐ Very likely ☐ Likely ☐ Neutral
☐ Unlikely ☐ Very unlikely

Feel free to write in additional information you think we should know about the health of our community.

_____
_____
_____

Thank you for your time!

APPENDIX C:

Oroville Hospital Community Needs Assessments
Focus Groups

This focus group is part of a required Community Health Needs Assessment for nonprofit hospitals. We are interested in learning from you whether Oroville Hospital's services are responsive to the needs in our community, and if you have suggestions about ways that the Hospital can improve services for the community?

Our interest in in learning from you about what how the Hospital is viewed and your experience or that of friends and family who have used its services. When we write our report, we will not use your name regarding anything that you say.

Furthermore, do not feel that you need to respond to each question and should you decide during our meeting that you do not wish to continue, we will understand and you are welcome to excuse yourself.

Introductions:
(For focus group participants: Please introduce yourself by sharing with us your first name, how long you have lived in the Oroville community, and whether you have ever used the services of Oroville Hospital?

Questions 1: What does a healthy community mean to you, and when you think about Oroville, what makes it healthy? What makes it unhealthy?

Question 2: Have you or a family member been treated or used the services provided by Oroville Hospital? What was the experience like?

Question 3: In our 2019 Community Health Needs Assessment, there were seven primary health concerns expressed. I will share each you and please let me know if they continue to be the same challenges for our community:

1. Substance Abuse;
2. Overweight/Obesity
3. Mental Health Issues
4. Access to Health Care Due to a. Shortage of Primary Care Providers
5. Heart Disease/High Blood Pressure
6. Diabetes
7. Homelessness/People in Poverty

Are there other primary health care concerns today that Oroville Hospital should address?

Questions 4: How does the community perceive Oroville Hospital? Are there reasons why someone would choose Oroville Hospital, and are there reasons why someone would not choose Oroville Hospital?

Question 5: Are you aware of barriers that may prevent people from using Hospital services?

Question 6: What could Oroville Hospital do to improve the community's utilization of its services?

Question 7: With COVID having been with us for the last two years, are there things that the hospital has done or could do to address COVID and a new pandemic?

Question 8: Is there anything else that you would like the Hospital to know?

APPENDIX D:

Oroville Hospital Key Informant Survey 2022

1. Which of the following best describes your occupation? (*Please select all that apply*)

- ☐ Behavioral Health Provider or Administrator ☐ Business Owner
- ☐ or Manager
- ☐ Cultural / Racial / Ethnic Organization Manager or Employee ☐ Elected or Appointed
- ☐ Official
- ☐ First Responder ☐ Government Employee
- ☐ Health Care Provider or Administrator ☐ Nonprofit
- ☐ Administrator or Worker
- ☐ Senior Focused Program Manager or Employee ☐ Youth Program
- ☐ Worker
- ☐ Other

If Other (please specify)

2. How long have you lived and/or worked in Butte County?

- ◯ 0-5 years
- ◯ 6-10 years
- ◯ 11-15 years
- ◯ 16-20 years
- ◯ 20+ years

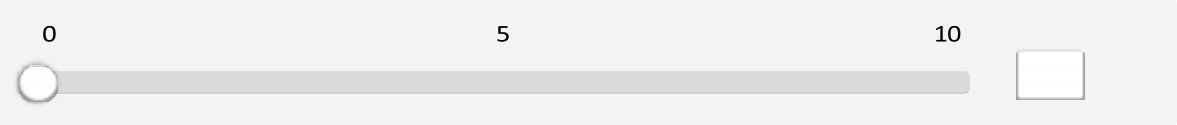
3. Have you previously participated in the Oroville Hospital CHNA?

◯ Yes ◯ No

4. What does a healthy community look like to you?

5. What is healthy about our community, and what is unhealthy?

6. On a rating scale of 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you rate Oroville Hospital?



7. Please explain why you chose this ranking.

* 8. Are you aware of any gaps in services and/or programs that would be beneficial for Oroville Hospital to offer?

- ◯ Yes
- ◯ No
- ◯ Unsure

9. Please describe any gaps in services and/or programs that you are aware of.

10. What can Oroville Hospital do to improve residents' health and quality of life?

11. Is there anything else that you would like to share concerning Oroville Hospital or unmet community needs?

APPENDIX E: Local Government Leaders

2022 Government Leader Contact List	
Name	Title
Butte County Representatives	
Bill Connelly	County Supervisor, District 1
Tod Kimmelshue	County Supervisor, District 4
Doug Teeter	County Supervisor, District 5
Andy Pickett	Chief Administrative Officer
Butte County Public Health	
Danette York	Director
Nanette Star	Assistant Director
Monica Soderstrom	Community Health Director
Elaine McSpadden	Environmental Health Director
Erin Cox	COVID Officer
Jodi Nicholas	Public Health Administration
Jodi Putnam	Public Health Prevention
Lisa Almaguer	Communications Manager/Public Information Officer
Gridley City Representatives	
Bruce Johnson	Mayor
Mike Farr	Council Member
J Angel Calderon	Council Member
Zach Torres	Council Member
Catalina Sanchez	Council Member
Cliff Wagner	City Administrator
Biggs City Representatives	
James "Bo" Sheppard	Mayor
Brian Bassett	Vice Mayor
Mike Buck	Council Member
Chuck Nuchols	Council Member
Jerome Squires	Council Member
Dennis Schmidt	Interim City Administrator
Oroville City Representatives	
Chuck Reynolds	Mayor
Scott Thomson	Vice Mayor
Janet Goodson	Council Member
Art Hatley	Council Member
David W. Pittman	Council Member
Krysi Riggs	Council Member
Eric J. Smith	Council Member
Bill LaGrone	City Administrator
Dawn Nevers	Community Development Department
Amy Bergstrand	Housing Development Department
Wade Atteberry	Parks and Trees Department
vacant	Public Works Department

APPENDIX F: Community Organizations and Leaders

2022 Community Leader Contact List		
Name	Title	Workplace
School Districts		
Kimberly Perry	President	Butte College
Mary Sakuma	Superintendent	Butte County Office of Education
Spencer Holtom	Superintendent	Oroville City Elementary School District
Corey Willenberg	Superintendent	Oroville Union High School District
Kathleen Andoe-Nolind	Superintendent	Palermo Union School District
Gregory Blake	Superintendent	Themalito Union Elementary School District
Joshua Peete	Superintendent/Principal	Golden Feather Union Elementary School District
Justin Kern	Superintendent	Gridley Unified School District
Jeff Ochs	Director of Alternative Education	Oroville Adult Education
Local Organizations		
Eric J. Smith	CEO	Oroville Chamber of Commerce
Shelton Enochs	President	Rotary Club of Oroville
Dean Hill	President	Oroville Exchange Club
Pastor Kevin Thompson	Chief Executive Officer/ Director	Oroville Southside Community Improvement Association/Southside Oroville Community Center
TJ Jensen	President	Downtown Oroville Business Association
Victoria Anton	Executive Administrator	Feather River Recreation & Park District
American Indian Organizations		
Benjamin Clark	Chairman	Mooretown Rancheria
Jennifer Santos	Tribal Administrator	Berry Creek Rancheria
Creig Marcus	Tribal Administrator	Enterprise Rancheria
Shelton Douthit	Executive Director	Feather River Land Trust/Tribal Health
Cultural Organizations		
Angel Yang	Director	Hmong Cultural Center of Butte County
Tiffany McCarter	Executive Director	African American Family & Cultural Center
Youth Programs		
Krysi Riggs	Director	The Axiom
TJ Jensen	Oroville Area Chair	Oroville YMCA
Jennifer Just	President	Lake Oroville Little League
Social Service Organizations		
Annie Terry	Director	Oroville Rescue Mission
Stephanie Hayden	Executive Director	Oroville Hope Center
Pastor Kevin Thompson	Program Coordinator	Haven of Hope on Wheels
Public Safety Organizations		
Kory L. Honea	Sheriff	Butte County Sheriff's Office
Bill LaGrone	Interim Chief	Oroville Police/Fire Department
Rodney Harr	Police Chief	Gridley Police Department
Marty Marshall	Managing Director	Butte County EMS

Top Economic Base Employers		
		Roplast Industries
		Pacific Coast Producers
		Sierra Pacific Industries